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1994 NATIONAL WOMEN AND DRUGS CONFERENCE: CHALLENGE, CONSENSUS AND CHANGE

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INTRODUCTION

This series of four issues papers was commissioned by the Drug and Alcohol Directorate of the NSW Department of Health for the *1994 National Women and Drugs Conference: Challenge, Consensus, Change.*

The aim of this conference is to provide an accessible forum for the exploration of a broad range of issues affecting women as a result of current policy and practice in the alcohol and other drugs field. In particular, it endeavours to promote a better understanding of women's drug use, to identify the barriers preventing equitable access to services for marginalised groups of women, and to develop strategies to overcome these in research, policy and clinical settings.

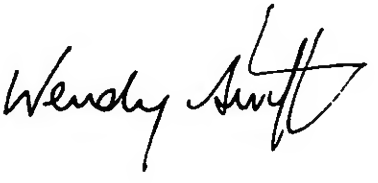
The conference organising committee approached the Drug and Alcohol Directorate of the NSW Department of Health for support. The Directorate recognised the importance of women's issues in the alcohol and other drugs field, particularly in terms of their implications for policy and practice and commissioned the preparation of these issues papers.

The papers address a broad range of important issues: models of service delivery, by Ms Barbara Kelly and Ms Denise McGregor; women and girls in custody, by Dr Lisa Maher; alcohol and other drug use among rural women, by Dr Ruth Sturmey, and the training and education of generalist workers by Ms Kinga Bisits.

Each of the papers underwent a tendering process, with the subsequent paper being peer reviewed by two others knowledgeable in the field before publication. The editors are delighted by the high standard of the papers, considering the constraints within which the authors had to work.

The aim of this monograph is to inform the conference proceedings by providing a critical overview of each of the relevant themes, and to establish some parameters for formalised feedback from conference participants regarding their own views of the important issues and priorities that need to be addressed.

We hope that you find these papers informative and stimulating, and that they prove useful in informing future policy, research and clinical work in the area of alcohol and other drug use among women.



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DRUG-RELATED ISSUES FOR WOMEN AND GIRLS IN CUSTODY*

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* The information contained in this paper is derived from multiple sources, including a review of the published literature; self-report information provided by government departments and state agencies responsible for adults and young persons detained in custody throughout Australia; and interviews conducted with a small opportunity sample of key informants, including professionals in the corrections field, drug treatment staff and clinicians, members of the target population and women drug users in the community.

EXECUTIVE SUMMARY

This paper examines the literature pertaining to alcohol and other drug related issues for women and girls in custody from an intersectoral perspective. The literature review is supplemented by self-report information provided by relevant government departments and state agencies throughout Australia and qualitative interviews with key informants, including professionals in the corrections field, drug treatment staff and clinicians, members of the target population and women drug users in the community. Within this context, the paper seeks to explore models of service provision for incarcerated women and girls with alcohol and other drug problems and to identify gaps in relation to research, policy and service delivery. The paper concludes by elaborating a number of recommendations for change.

I THE LITERATURE

1.0 Incidence and Prevalence of Drug Use Among Offender Populations

A growing body of evidence, both in Australia and overseas, attests to the fact that known offender populations[1] are composed of large numbers of drug users. In the United States, the results of urinalysis among arrestee populations suggest that increasing proportions of those who come into contact with the criminal justice system are users of illicit drugs. Although rates exhibit considerable regional variation, illicit drugs are routinely detected in the urine of between 40 and 70% of arrestees (Drug Use Forecasting, 1990)[2]. Over the past decade, these results have consistently indicated that among arrestee populations, women are more likely than men to test positive for illicit drugs (Richardson, 1979; Wish et al., 1981; Wish et al., 1992; Wellisch et al., 1993; Graham and Wish, 1994)[3]. However, little is known about drug use among arrestee populations in Australia and information on drug use at the point of entry into the criminal justice system is not routinely recorded. While urinalysis is increasingly used in prison systems, arrestees are not currently tested, nor are their any plans to introduce such testing.

A parallel body of research is concerned with drug use among imprisoned populations. In the United States, where women constitute a relatively small segment of the prison population (5.7%), the majority of women (59%) are incarcerated for non-violent crimes. Between 1980 and 1989, there was a 307% increase in the number of women arrested for drug law offences including the possession, manufacture and sale of illicit drugs, compared to male arrests which increased by 147% over this same period. While the percentage of women imprisoned for drug offences exceeds that of men, in 1986, only 15% of women imprisoned in state correctional facilities were convicted of drug offences (Bureau of Justice Statistics, 1991; Chesney-Lind, in press).

A recent survey of state prison inmates in the U.S. revealed that 72% of women had used illicit drugs at some stage in their lives with just under half (46%) reporting using drugs or alcohol at the time the imprisonment offence occured. One third of all female inmates indicated that they were under the influence of a "major" [illicit] drug (cocaine, heroin, methadone, LSD or PCP) at the time of their offence; 39% were using drugs daily in the month before their offence and 24% reported daily use of a major drug in that month (Bureau of Justice Statistics, 1991). These data suggest that women were more likely than men to have been using heroin or cocaine in the month prior to imprisonment, more likely to be daily users and more likely than men to have been under the influence of major drug/s at the time of the instant offence (Bureau of Justice Statistics, 1991).

In Australia, licit drug use, and in particular, the use of alcohol is perceived to be a major problem among imprisoned populations. In a Tasmanian study, White and Boyer (1985) found that 43.5% of inmates were dependent on alcohol. In Western Australia, Indermaur and Upton (1988) found that one third of prison inmates consumed "hazardous" amounts of alcohol on a daily basis prior to imprisonment. A survey of prisoners upon reception to New South Wales gaols indicated that 66% used alcohol more than once a week and almost one third were daily users in the twelve months prior to imprisonment (Stathis et al., 1991). This study also found that inmates using alcohol were significantly more likely than inmates using other drugs to report committing violent offences such as homicide and assault.

High levels of alcohol use are thought to be especially prevalent among populations of Aboriginal inmates and young offenders. Although there have been few attempts to define the nature and extent of alcohol use among these populations, an early study conducted in Western Australia found that 74% of Aboriginal prisoners classified themselves as "really drunk" at the time of the offence for which they were imprisoned (Duckworth et al., 1982). Recent research conducted in NSW indicates that Aboriginal inmates (88.9%) are significantly more likely to perceive their imprisonment as drug-related than non-Aboriginal inmates and in particular, to report their imprisonment as related to alcohol use (Stathis et al., 1991:15).

Although little is known about the alcohol consumption patterns of young female offenders, recent research has highlighted the role of alcohol in offenses committed by young persons. Putnins and Harvey (1992) found that the majority of respondents (56.9%) in their survey of youthful detainees in South Australia indicated that they had been drinking at the time of the offense (Putnins and Harvey, 1992). In NSW, Zibert et al. (1994) found that more than three quarters (76%) of young detainees in their sample drank alcohol in the month prior to incarceration. Almost two thirds (63.1%) reported consuming five or more standard alcoholic drinks on at least one day during the two weeks prior to their incarceration. On average, detainees consumed five or more standard drinks on six out of the fourteen days prior to incarceration. The average number of standard drinks consumed by respondents on a typical drinking day was 24.8 (Zibert et al., 1994:50).

In relation to adult female offenders however, some evidence suggests that as a group, women prisoners tend to report lower levels of alcohol use and alcohol-related problems than their male counterparts and higher levels of illicit drug use and associated problems (Miner and Gorta, 1986; Denton, 1994)[4]. For example, in their survey of women in prison in NSW, Miner and Gorta (1986) found that while only 10% reported the regular use of alcohol, 69% used illicit drugs exclusively and a startling 66% were identified as heroin users, the majority of whom had long term, large, daily habits. Similar findings emerge from a recent study of imprisoned women in Victoria which found that while 9% of women had a pre-arrest alcohol dependence disorder, 50% were diagnosed as opiate dependent (Denton, 1994). Given the paucity of literature on alcohol use and related problems among female offenders, and the fact that the few studies which exist suggest that illicit drug use is likely to be more prevalent in this population, the remainder of this paper primarily focusses on illicit drug use.

Estimates as to the prevalence of illicit drug use among imprisoned populations in Australia range between 35 and 97% of the population[5]. Dobinson and Ward (1985) found that 39.5% of NSW property offenders were regular or heavy users of barbituates, cocaine, heroin and/or other opiates prior to arrest. Studies conducted in other states suggests that rates of drug use among imprisoned populations may be even higher. Indermaur (1986) found that 87% of inmates surveyed in Western Australia reported that alcohol or drugs were related to their imprisonment. In a study of South Australian inmates, Visser (1986) found that between 50 and 70% of inmates had alcohol and drug-related problems.

A recent survey of NSW prisoners upon reception found that 97% had tried at least one illicit drug and 62% believed that their current imprisonment was related to the use of alcohol and/or other drugs with 70% reporting drug use in the 24 hours preceding their offence (Stathis et al., 1991). Inmates who used illicit drugs exclusively or illicit drugs in combination with alcohol were found to be more likely than those who consumed alcohol

alone to report committing property offences or robbery with assault and less likely to report committing offences such as homicide and assault (Stathis et al., 1991).

As in the United States, the proportion of women in prison in Australia with substance use problems is believed to be higher than for males. Willson (1987) has claimed that 85% is a conservative estimate of the extent of drug use among women in prison. The NSW Women in Prison Task Force found that 78% of female prisoners were daily consumers of alcohol and/or illicit drugs prior to arrest with heroin being the most commonly used drug (Women in Prison Task Force, 1985; hereafter WIPTF). A subsequent study of women prisoners, also in NSW, found that 79% reported drug use prior to imprisonment and 66% indicated a history of heroin use, either alone or inconjunction with other illicit drugs (including cannabis, serapax, cocaine, "pills", amphetamines, barbituates and mandrax). Heroin users had an average use period of four years and five months with a range of three months to ten years and the majority reported daily use at the time of the instant offence (87%). Heroin users were also more likely to be unemployed (85%) compared to non users (79%) and more likely to cite illegal activities as an income source than non users (32% versus 5%) (Miner and Gorta, 1986).

Similarly, research conducted in other states also indicates a high incidence of substance use among female prisoners. A study of women prisoners in Queensland found that 55% had a history of substance use disorders (Hurley and Dunne, 1991). In Victoria, Denton (1994) identified 61% of women prisoners as having a "pre-arrest substance dependence disorder", with a significant proportion of women dependent on multiple substances. While this research confirms the prevalence of opiate dependence (50%) among this population, it also highlights alarming patterns of benzodiazepine consumption (29%) among imprisoned women. Almost three quarters (71%) of the women in Denton's study were imprisoned for property or alleged property offenses and almost half were serving sentences of twelve months or less (Denton, 1994).

In contrast to the U.S, where the proportion of females serving sentences of imprisonment for drug offences has risen dramatically over the last five years (Chesney-Lind, in press), data from the National Prison Census indicate a substantial decrease in the number of female prisoners in Australia with a drug offence as their most serious conviction. Compared to the proportion of male prisoners serving sentences with drug offences as their most serious conviction which has remained relatively stable at between 9 and 11%, female drug offenders declined from 21.1% of the female prison population in 1986 to 14.1% in 1992 (Walker and Biles, 1987; Walker, 1993).

However, as Miner and Gorta (1986) have pointed out, sentencing data do not provide a reliable indicator of the total level of drug offences among women in prison. While approximately 26% of all female prisoners in NSW were serving sentences with drugs offences as their major offence at the time of their study, by including women with a past record of drug offending, Miner and Gorta calculated that a majority of women (62 or 60%) in their sample had a record of either current or past drug offending.

Finally, evidence suggests that, like their adult counterparts, incarcerated young offenders display rates of drug use far in excess of those recorded in age comparable general population surveys (Crundall, 1987; Zibert and Howard, 1989). Based on a sample of detainees in

Victorian Youth Training and Reception Centres [67% male], Crundall (1987) found that 50% reported ever having used stimulants and inhalants, 42% reported the use of hallucinogens and 32% had ever used narcotics. In a survey of young detainees in NSW [90.1% male], Zibert and Howard (1989) found that more than 60% had used seven or more different drugs. More than half had ever used stimulants and a significant minority (25.8%) had used narcotics. Of these respondents, 26.1 % had used stimulants more than 40 times and 15.8% had used narcotics on more than 40 occasions. Less than a third (29%) of these young people had experience of any form of drug rehabilitation and only 8% had ever participated in a residential drug treatment program.

A recent replication and extension of the 1989 study (Zibert et al., 1994) [96% male, 35% Aboriginal; 15% NESB] tends to confirm earlier findings related to drug use and treatment experience. The 1994 study found that almost half (49.1%) of respondents considered that they had a past problem with drug use compared with 33.3% in the 1989 study and almost one quarter (24.4%) regarded their current use as problematic, compared with 25.8% in 1989 (Zibert et al., 1994).

While little research has focussed specifically on young female offenders, a 1986 report which sought to "give voice" to the experiences of 100 'girls at risk' in NSW found that 67% had used illicit drugs and/or alcohol (Girls At Risk, 1986). More recently, a review of juvenile justice conducted by the NSW Youth Justice Coalition concluded that,

> [A] higher proportion of girls than boys ... had serious drug problems, for which there was little or no treatment available (1990:314).

The tragic deaths of six young women shortly upon their release (three being escapees) from custody in NSW during an eight month period between May 1990 and January 1991 highlights the inadequacy of current justice system responses to the needs of young women. The cause of death for each of these young women, four of whom were Aboriginal, was determined as a drug overdose (Bargen, 1993). At least one of these young women was sexually abused while in police custody and had indicated suicidal tendencies while in detention (Cuneen, 1991). Based on the averaged monthly population for this period, these six young women represented approximately 22.5% of the incarcerated female young offender population (NSW Department of Juvenile Justice, 1994). However, despite the intimation of an alarming post-release mortality rate among young female detainees in NSW, these deaths prompted little more than a passing (and highly sensationalized) media curiosity[6].

1.1 The Criminal Justice System Response

Drug research has long been preoccupied with establishing the temporal sequencing of the relationship between illicit drug use and crime[7]. While the view that drug use "causes" crime remains one of the "highly cherished beliefs" (Inciardi and and Pottieger, 1986:101) of drug research, a growing body of literature suggests that rather than drug use precipitating criminal involvement, involvement in lawbreaking may precede regular drug use (especially heroin and crack cocaine use). In this view, drug use can be seen as an extension of a "deviant" lifestyle, at least for those in contact with the criminal justice system.[8] More promising perhaps is recent research which abandons the search for causality in favour of an

examination of the conditions under which drug use and crime are associated and develop together (e.g. Hammersley et al., 1989).

Nonetheless, it remains a popular commonsense that women in prison with drug and alcohol related problems gain entree to the criminal justice system because of their substance use - i.e. drug use precedes criminality (e.g. WIPTF, 1985; Fitroy Legal Service, 1988). While there have been few studies which have sought to explore the temporal sequencing of drugs/crime in relation to women offenders, some overseas research tends to suggest that criminality precedes addiction among this population. For example, drawing on data collected on two cohorts of active women narcotics users in Miami, Inciardi and Pottieger found that "criminal activity emerged concomitant with drug experimentation, and regular use of heroin and other narcotics began only several years after the onset of crime" (1986:104; see also Inciardi et al., 1993 for similar findings in relation to female crack use).
These findings are consistent with an examination of the conviction sequences of 62 women incarcerated in NSW which found that while 44% had been convicted of drug offenses prior to any other conviction, a slight majority (56%), had been convicted of other offences before any drug offense (Miner and Gorta, 1986:14). Conversely however, a recent study of 313 applicants for methadone maintenance (Hall et al., 1993a) found that while the sequencing of heroin use and criminal activity was clearly differentiated by gender, women were more likely than men to commence heroin use prior (and in some instances, well prior) to their first conviction for a property offence. In many instances the reliance of women on prostitution as an income generating strategy appeared to have alleviated the need for involvement in property crime (Hall et al., 1993a).

Although little is known about the precise nature of the connection between drug use and crime, the two are clearly related and increasing numbers of drug offenders are being brought to the attention of the criminal justice system. For the most part however, criminal justice systems have failed to develop strategies for routine detection and intervention in relation to drug use by arrested and convicted persons. Justice systems tend to focus almost exclusively on criminal processing functions of arrest, conviction, disposition (including incarceration and community alternatives) and post-release supervision. To date, few efforts have been made to routinely identify drug users, record information about their use, provide comprehensive and sustained treatment interventions while in custody or to refer them to community treatment and after-care programs. As a recent review of the literature suggests:

> "If governmental agencies and indeed society in general are seriously interested in reducing criminal activity, particularly that of a recidivist nature where drugs and alcohol often play a significant role, then urgent attention must be focussed on the issue of the assessment and treatment of drug and alcohol problems in the prison population" (Westmore and Walter, 1993:190).

Nowhere is this more apparent than in relation to female offenders whose needs have gone largely unmet in the context of a male-dominated criminal justice system (e.g. WIPTF, 1985)[9].

1.2 The Efficacy of Criminal Sanctions

There is little evidence to support the view that criminal justice sanctions alone are as effective as drug treatment in reducing the incidence of both drug use and lawbreaking among illicit drug users. The extent to which imprisonment alone suppresses post-incarceration lawbreaking or illicit drug use among drug using offender populations is unknown. The limited evidence available from treatment evaluation studies (reviewed in Section 1.3 below) indicates that, 'untreated', at least two thirds of convicted heroin users resume drug use and lawbreaking within three months of release from prison. Nonetheless drug treatment programs in correctional settings face a pervasive commonsense in the belief that, in order to be successful, drug treatment must be voluntary. It is widely held that sentencing or remanding drug users to prison or to community based treatment programs as a way of forcing them to deal with their drug problem neglects the role of motivation as a critical element determining successful treatment outcomes (e.g. Fitzroy Legal Service, 1988). However, the role of motivation as a factor influencing treatment outcome has typically been emphasized in relation to treatment modalities which assume a goal of abstinence as the only, or primary, treatment aim. Consistent with the adoption of a philosophy of harm minimization, recent shifts towards recognition of a heirarchy of treatment goals, including the reduction of HIV risk taking behaviours and reductions in criminality, may serve to reduce resistance to treatment by particular groups of users[10]. Notwithstanding this trend, the fact remains that the criminal justice system is capable of exerting a certain amount of leverage over convicted and/or incarcerated populations that could be utilized to bring drug users into treatment. The question then, is whether treatment under such conditions is effective.

Several studies of treatment outcomes with criminal justice clients in the United States suggest substantial post-treatment reductions in both drug use and criminality (Field, 1985, 1989,1992; Anglin, 1988; Anglin et al., 1988; Hubbard et al., 1989; Wexler et al., 1990; 1992). Evidence also suggests that criminal justice system coercion may bring users into their first treatment episode earlier in their career and that they are retained in treatment longer (Collins and Allison, 1983). In a recent review of the literature in which they identify length of time in treatment as "highly correlated with positive treatment outcomes", Anglin and Hser conclude that "clients entering treatment under legal coercion do as well by most outcome criteria as volunteer clients and may stay in treatment longer" (1990a:313; see also Hubbard et al., 1989).

Indeed, an increasing body of research suggests that the coercive power and surveillance potential offered by criminal justice sanctions may provide significant opportunities for successful treatment interventions (McGlothlin, 1979; Leukefeld and Tims, 1988, 1992; Anglin, 1988; Anglin and Hser, 1990b). The leverage created by the threat of legal sanctions and by the sanctions themselves may serve to permit consideration of treatment as a viable option by the user. Evidence from the United States suggests that while relatively few arrested offenders voluntarily seek drug treatment (Hunt et al., 1984; Johnson et al., 1985; Wish et al., 1986, 1992)[11], when faced with an alternative of incarceration, some drug users may prefer referral to drug treatment.

Historically, prison systems have placed little emphasis on presenting treatment programs as an attractive alternative. The result has been that few drug users in custody volunteer for treatment. Prison inmates typically seek prison treatment programs in order to gain better

living conditions, a safer environment, and parole release considerations, as well as the opportunity to change one's lifestyle and reduce drug use. To date there is little evidence in the Australian context to suggest that drug treatment has been specifically targetted or "marketed" to incarcerated populations as an attractive option which is readily accessible and does not entail significant opportunity costs, such as the loss of income from prison employment (Section 3.1, (vi) below).

In summary, research to date, conducted primarily on male offender populations, suggests that the threat of sanctions (for arrestees) or the promise of better living conditions (for inmates) may operate as an incentive to treatment for some offenders and may serve to improve retention rates. Further incentives to treatment may also be expected to accrue if the current trend towards a reduced emphasis on abstinence-based treatment goals continues. Unfortunately, little is known about women as most of the literature reviewed here is either based on, or primarily concerned with, male offenders.

1.3 Dimensions of Effective Drug Treatment

The great bulk of the treatment literature focusses on interventions in relation to alcohol, heroin and increasingly, cocaine. Little is known about the efficacy of treatment in relation to other kinds of illicit drug use such as amphetamines and benzodiazepines or indeed, multiple substance use. It is also important to note that while studies of treatment effectiveness are limited by the lack of research which utilizes randomised control trials and other forms of controlled evaluation, such research is further compromised by a failure to include sufficently large numbers of women for the data to be analyzed by gender.

Research that does exist however, indicates that the criminality of heroin users can be substantially reduced while they are receiving some form of treatment. Despite the frequently cited conclusion that "nothing works" in the correctional setting (e.g. Martinson, 1974), there is a small body of evidence to suggest that some custodial programs have been successful in reducing recidivism for some offender populations. The majority of these successful offender rehabilitation programs have been based on variants of social learning theory which posits that crime and drug use, like most behaviour, are learned through a process of social interaction with others and can therefore be "unlearned". Effective approaches identified in the literature include: structured therapeutic communities, self-help groups, family therapy, contingency contracting, role playing and modelling, vocational and social skills training, training in interpersonal cognitive problem-solving skills, and a range of programs which involve ongoing peer monitoring of behaviour[12].

This literature also identifies a number of factors that impact treatment integrity and impede program success. Many of these factors are common to intervention programs in any setting. The absence of any sound theoretical basis for treatment is a typical barrier to the development of successful programs. The quality and intensity of treatment interventions are often inadequate. Some programs impose treatment interventions that, while based on sound principles, are not followed through when the program is implemented. A common problem is a lack of staff training and treatment experience, and/or inadequate commitment to both participants and program success. As Anglin and Hser (1990a) point out, "Of all the aspects

of treatment structure, program policy and its execution by staff are perhaps the least quantifiable and least studied in terms of its effect on treatment outcomes" (1990a:361).

Although few studies have addressed these critical components, Anglin and Hser report the results of a study of three methadone programs in Southern California which suggests that programs with flexible policies in relation to both doseage and discharge for program infractions exhibit improved retention rates over programs with a more punitive and less flexible orientation (1990a:361). In Australia, recent research by Bell et al. (1992), also in relation to methadone, confirms the existence of a relationship between program "tolerance" and retention in treatment.

In contrast to alcohol treatment, where length of time in treatment is generally believed to be a poor predictor of outcome (Miller and Hester, 1986), recent research suggests that a critical dimension of treatment programming for illicit drug users is length of time in treatment (Anglin and Hser, 1990a). Although in general, treatments of less than ninety days duration appear to be of limited benefit, except for detoxification purposes (Simpson, 1979; Simpson and Sells, 1982), research indicates that treatment outcome improves over time and that the longer clients remain in treatment, the greater the reduction in post-treatment drug use, criminality and other outcome measures (McGlothlin and Anglin, 1979; Simpson, 1979,1981; Leukefeld and Tims, 1992). These findings hold whether treatment takes the form of community-based therapeutic community programs (DeLeon et al., 1979), prison-based therapeutic community programs (Wexler et al., 1985; 1992) or methadone maintenance programs (Ball et al., 1987; Ball and Ross, 1991).

Other impediments to the establishment and maintenance of successful treatment programs are specific to the criminal justice system and typically relate to a lack of justice system support and the negative influence of inmate subcultures. Fundamental differences between custodial and treatment perspectives often contribute to the failure of the prison environment to support program staff and goals. The lack of support from custodial staff is exacerbated by the negative influence of anti-authoritarian and anti-therapeutic inmate cultures whereby suspicion and mutual hostility condition interactions between staff and inmates.

For incarcerated heroin and cocaine abusers who participate in prison-based therapeutic community programs, the optimum period of treatment appears to be nine to twelve months, followed by release into the community, with longer stays associated with diminishing results. This appears to be due to two factors. First, longer periods of program participation in prison may create increased dependency on the program and less transference of the learned experiences back to the community upon release. Secondly, when prisoners are transferred back to the general inmate population as "rehabilitated", the inmate subculture and the depressing and often stressful conditions of prison life may undermine some of the gains made during the program and exacerbate the potential for relapse. Thus the timing of treatment and release for prison inmates should be coordinated to achieve optimum outcomes.

There is however, a body of literature that maintains that the prison environment is inherently unsuitable for treatment programs. Indeed, the NSW WIPTF concluded that "The prison environment generates conditions which are in total contradiction to those designed to promote rehabilitation" (1985:79; see also Newman, 1977). Drug treatment programs in prison are held to be futile because of the inherent conflict between security and rehabilitation

(Smith, Beamish and Page, 1979). As a recent Victorian study concluded, "[Treatment] cannot outweigh the negative factors of imprisonment that reinforce low self esteem and dependency which contribute to addiction" (Fitroy Legal Service, 1988:12).

Despite the pessimism inherent in such an approach, a recent review of drug treatment in prisons and jails in the United States includes a number of studies which conclude that effective prison-based treatment is possible (Leukefeld and Tims, 1992). In summary, this emerging literature indicates that the following components will be of particular importance to offending populations: a lengthy period of intervention; a significant level of structure such as residential treatment, at least initially; the employment of ex-offender and ex-addict counsellors; flexible policies in relation to client management, particularly in relation to the use of punitive sanctions for intermittent drug use; education, skills training and the provision of legitimate economic opportunities (to prevent re-immersion in the drug economy); and substantial post-release support.

Finally, it is important to note that the paucity of research on treatment outcomes for women is exacerbated among offender populations where women are typically regarded as "too few to count". Although there have been a handful of reports concerning prison-based modified therapeutic community programs for female offenders (e.g. Bishop et al., 1987; Criswell, 1989), the only published controlled evaluation indicates mixed results. Based on their study of the "Stay 'N Out" women's program at New York's Riker's Island facility, Wexler et al. (1992) report that although women in the therapeutic community group did better than women assigned to counselling or those who received no treatment on some outcome measures, overall differences between the three groups were not significant.

In summary, these data suggest that women who participated in the therapeutic community treatment were significantly less likely to be arrested in comparison with the counselling group but there were no statistically significant differences between the female therapeutic community group and the no treatment group. Women in the therapeutic community group also had a significantly higher percent positively discharged from parole than the no treatment group but differences between the therapeutic community group and the counselling group failed to attain significance. The study also failed to find statistically significant differences between the three female groups in terms of the mean number of months to arrest (Wexler et al., 1992).

1.4 Summary

Although no treatment intervention, and in particular, no criminal justice system based intervention can realistically expect to eliminate drug use among offending populations, even if an intervention suceeds only in reducing the volume and frequency of use, substantial reductions in the harms associated with the consumption of alcohol and illicit drugs may eventuate. The principle of harm minimization has broadened the range of possible treatment goals beyond the limited objective of abstinence to include goals such as reduced consumption, controlled use, changes in modes of administration, and the reduction of criminality and HIV risk behaviours. Research suggests that heroin and cocaine abusers commit much less crime when they use only once or twice a week than when they use on a daily basis (Johnson et al., 1985; Nurco et al., 1985; Sanchez and Johnson, 1987) and that

treatment significantly reduces HIV risk behaviours among injecting drug users (Ball et al., 1988; Darke et al., 1990).

However, as Anglin and Hser have argued in the North American context, "The use of public resources for drug treatment remains controversial. To some, it seems inappropriate to provide services to what is considered a criminal population ...a pervasive public disappointment with drug treatment has emerged, despite extensive positive findings ... and a reduced interest in the social rehabilitation of deviant individuals" (1990a:364). Yet as they point out, other publicly funded services such as hospital beds, emergency room facilities and criminal justice system resources are all more heavily utilized by drug users when they are not in treatment.

To date little attention has focussed on the role of treatment programs in reducing the social, as well as the individual costs of drug abuse. Such an approach necessitates consideration of the costs of law enforcement activities, institutional well-being[13], drug-related crime, drug-related mortality and morbidity, public health consequences such as the spread of HIV/AIDS, hepatitis, tuberculosis and sexually transmitted diseases, loss of economic productivity and the fear of drug-related victimization. Recent research in the United States indicates that in relation to drug-related criminality, treatment costs are almost entirely recovered during the period of treatment (Hubbard et al., 1989). As Hubbard et al. concluded of their prospective study of more than 11,000 drug users involved in 41 different treatment programs throughout the United States, in addition to substantial reductions associated with reduced criminal activity:

> "drug abuse treatment results in substantial improvements in other negative behaviors, which may further reduce the costs incurred by the nation. For instance, productivity gains may be made by those who are not criminally involved, and treatment will most likely result in lower demand for social services by this population. A major economic benefit in the future will likely be from the prevention of AIDS among intravenous drug users and their sex partners. Thus, while drug abuse treatment has been shown to be a good return on investment simply in terms of crime reduction, the returns may be substantially greater than those estimated here" (Hubbard et al, 1989:161-162).

The adoption of harm minimization as an integral component of Australia's National Drug Strategy implores recognition of a range of treatment goals and the development of appropriate intervention strategies designed to assist in minimizing the harms associated with alcohol and other drug use. Legitimately included among these is the reduction of criminal activity. As Mattick and Hall have recently argued:

> "Although some regard a reduction in criminal behaviour among injecting drug users as an inappropriate goal for drug treatment, arguing that this constitutes 'social control', there can be little doubt that injecting drug users who are incarcerated as a result of criminal activity can suffer negative consequences which are associated with imprisonment. Therefore, it is quite legitimate to include a reduction in criminal behaviour as an important goal of drug treatment" (1993:75).

II MODELS OF SERVICE PROVISION FOR WOMEN AND GIRLS IN CUSTODY

There are currently 760 women and some 41 girls under the age of 18 detained in prisons and juvenile detention centres throughout Australia (Walker, 1993; Australian Institute of Criminology, 1994). Women in prison constitute approximately 4.8% of the total adult prison population[14] while young women represent almost 7% of juveniles in detention. Historically, drug and alcohol services to imprisoned populations have tended to focus on older adult males serving long sentences for serious offences and with a long history of drug and alcohol abuse. While most jurisdictions have taken steps to remedy this situation, prison-based interventions have been slow to recognize the prevalence of multiple drug use among offender populations and in particular, the consequences of poly-drug use for imprisoned women.

Despite an increase in both the level and quality of drug education, the introduction of HIV education and awareness programs and the introduction and extension of methadone programs in some jurisdictions, the current major treament modalities for women and girls in custody in Australia have changed little over the past decade. Moreover, there is information to suggest that in some women's prisons, the repressive conditions and unecessarily brutal realities of particular regimes may work to undermine the effectiveness of treatment interventions. As noted by a female prisoner in NSW in a recent submission to a community legal service:

> "Although attempts have been made in Mulawa to offer Drug and Alcohol Services and to expand education, while such an overall repressive policy operates, rehabilitation is a lost cause ... As it now exists, the system breeds cynicism, hostility and deep resentment. I see women return here again and again. Many never see a therapist, many are too depressed or stunned to even ask to see one. They are released with a Welfare cheque, often with nowhere to go. They return to the life of crime they know and they have little option" (Lamont, 1994:2).

More generally, there is ample evidence within the Australian context to support Anglin and Hser's (1990) contention that within the correctional setting, "Typically, such programs are short-lived - developed under one administration and terminated under subsequent ones" (1990a:344). While until recently, Victoria operated a therapeutic community program for women, along with Western Australia and Tasmania, Victoria now contracts out the provision of drug and alcohol services to the prison population. Other jurisdictions provide direct services through institutionally based drug and alcohol workers to women (NSW, Queensland) and girls (NSW, Victoria, ACT) in custody. The Northern Territory currently utilizes Department of Correctional Services employees to conduct an alcohol program for women in prison and the ACT provides one session dealing with "addictive behaviours" as part of an eight session pilot "personal development" program for incarcerated women. Although a drug and alcohol program has recently been instituted for young males, South Australia does not currently provide any drug and alcohol services to young women in custody. Only NSW and Queensland reported the provision of specialist drug and alcohol services to Aboriginal women.

2.0 Detoxification

The issue of a detoxification unit at Mulawa, the principal women's prison in NSW, has been a constant source of controversy for almost two decades with at least one documented case where a woman died undergoing unsupervised withdrawal[15]. The WIPTF report (1985) universally condemned medical and custodial staff at Mulawa for their punitive and unsympathetic attitudes towards women undergoing drug withdrawal and commented at length on the denial of pain relief and access to showers or baths and the refusal of assistance to women in this condition. However, almost a decade after the WIPTF recommended that a detoxification unit be established to provide "safe, monitored, sympathetic and medically adequate withdrawal", women prisoners in NSW remain without a detoxification facility[16]. Where medically indicated, women may be placed in the hospital annexe although the shortage of beds and the undesirability of annexe accommodation results in most women undergoing "medically monitored" but for the most part, unsupervised detoxification in the general inmate population.

Based on the information provided by the relevant authorities in each state, detoxification - in the form of a specialist inpatient medically-supervised withdrawal program - does not appear to be currently available in any women's prison or juvenile facility which houses young women in Australia. Women withdrawing from drugs are either placed in the general population or in some circumstances, are housed in isolation in observation cells under the supervision of custodial staff. As has been noted in relation to Victoria, women in observations cells are often left unattended at night (Denton, 1994). Not suprisingly, recent research in Victoria found that 79% of women believed existing provisions for drug detoxification in prison to be unsatisfactory (Denton, 1994).

A study of inmates upon reception to NSW prisons, 46% of whom reported that they were dependent on alcohol and/or other drugs found that 32% indicated that they expected to or were already experiencing withdrawal from alcohol and/or other drugs (Stathis et al, 1991). However, a study of inmates about to be released in NSW, 63% of whom were drug users, found that more than half of the 22% who reported that they were withdrawing from alcohol and/or other drugs did not receive any treatment for their symptoms. Of those who did receive treatment, nine were withdrawing from more than one drug, with the most common combination being pills and heroin. Only two inmates reported that their condition was monitored during detoxification (Kevin, 1993:8).

These findings are disturbing given reports of high levels of poly-drug use among offender populations (e.g. see Stathis et al, 1991[17]; Denton, 1994[18]) and the need for withdrawal to be closely monitored given the high risk of health complications. Moreover, given the traditional reliance on the licit use of these drugs in women's prisons (Section 3.1 (iv) below), it is likely that differences between prison prescribers, staff changes and inter-prison transfers may also precipitate acute withdrawals and the need for supervised detoxification. As one of the women in Hampton's recent (1993) study of women in prison in NSW recalled:

> "At Bathurst they put me on all this psych medication ... By the time I went back to Mulawa I was really strung out on these pills and the doctor at Mulawa cut me off them immediately. I went back to Catchpole and within 24 hours my left side went all funny, and my joints were aching, my arm was

> aching all down one side and I couldn't see in one eye. I went back to the medical staff the next day and I was really hysterical. I felt like I was going to have a stroke and I demanded to see the psych[iatrist] who put me straight back on the pills I'd had and then weaned me off them properly" (cited in Hampton, 1993:106).

Finally, despite the assumption of a need for prison-based detoxification facilities, there is some anecdotal evidence to suggest that detoxification needs are often more acutely felt at any earlier stage of criminal justice system processing and as such, should appropriately be serviced by police. Indeed, Denton (1994) found that when asked about the "experience of drug treatment in prison", many of the women in her study responded with details concerning their treatment in police custody, including being subject to physical and emotional abuse (1994:50). There is however, a dearth of research in relation to police practices regarding the arrest, detention and questioning of drug users. Despite considerable anecdotal information, to date no studies have attempted to examine the nature of the police processing function and its implications for drug using arrestee populations.

2.1 Self-Help Groups

As Mattick and Hall have noted in relation to a recent review of treatment effectiveness for opioid users, there appears to be no evidence in the research literature in favour of the efficacy or otherwise of self-help groups and their effectiveness remains unknown (1993:55).

In the prison context, self-help groups such as Narcotics Anonymous are essentially cost free programs run by "recovered" persons who volunteer their time. However the policies of most prison departments preclude volunteers with criminal records from entering prisons to perform this function. While there is no evidence to suggest that this may temper the effectiveness of such programs, given their function as a peer support system and the use of counsellors as role models, the absence of ex-offenders in this context could reasonably be expected to diminish their efficacy. Indeed such policies may account for why several administrations reported difficulties in conducting Narcotics Anonymous meetings due to a "lack of availability of community participants".

Despite this obvious drawback, self-help groups in the form of Alcoholics Anonymous and Narcotics Anonymous appear to be widely utilized by adult and juvenile justice systems throughout Australia. Finally, while the peer support/education model appears to have been relatively successful in the HIV/AIDS area, to date few efforts have been made to explore the utility of this model in relation to prison-based drug and alcohol interventions.

2.2 Therapeutic Interventions

(i) Individual Counselling

All of the jurisdictions surveyed claimed to provide individual counselling services to the target population although the nature and content of the therapy and the backgrounds of service providers varied considerably. Individual counselling for adult women is provided by psychologists (Victoria), drug and alcohol workers (NSW, Queensland) and counsellors from

a community drug treatment agency (Tasmania). Specialist individual drug and alcohol counselling is provided for young female detainees by drug and alcohol workers (NSW, Victoria), psychologists and counsellors from outside agencies (Western Australia) and a psychotherapist (NSW).

Given the reported high prevalence of sexual and physical abuse in the backgrounds of women prisoners, such an approach is consistent with evidence that suggests such women may be more receptive to individual therapy (e.g. Copeland et al., 1993). More important in the prison context than the actual mode of individualized therapy however, may be the institutional constraints which the prison environment and its requirements of "good order and security" place on effective therapeutic interventions. As one of the women interviewed in Hampton's recent study told her:

> "A psychologist is available, although the ability to maintain a regular consultation is limited, due to lack of staff, the waiting list being so long, or the psychologist having little belief in what you relay confidentially. There is no place for a second opinion, so if a personality clash or the like develops, the professional can actually stop your progress through the system and your chances of parole. Very dangerous situation to be in with nowhere to go for advice or help" (cited in Hampton, 1993:105).

(ii) Group Counselling

Among the prison and youth detention centre jurisdictions for which data were provided, group counselling was reported by five of the jurisdictions responsible for adult females (NSW, Victoria, Queensland, Tasmania and the Northern Territory [alcohol only]) and four of the jurisdictions responsible for young women in custody (NSW, Victoria, ACT and Western Australia). Although programs provided to the general prison population in the past by these agencies included drug education, general health (including HIV) education, anger management, relapse prevention, stress/ relaxation, 12 step groups, smoking cessation, motivation and self-esteem, it was not clear whether all or any of these programs were made available to women, or on what basis. None of the adult programs included specialist women's groups. Victoria was the only state operating an active peer education program for young people in custody and NSW recently established a separate 21 bed facility committed to the principle of recognizing the special needs of young women in custody (e.g. see Cain, 1994; Cozens, 1993).

However, while group counselling appears to be a commonly used modality in prison-based programs, it may not be the most effective approach. As Lipton et al. have suggested "[Group counselling] in most institutions is particularly beset by the pervasive antisocial pro-criminal inmate subculture" (1992:13). For women in prison, the costs attached to revealing weaknesses or vulnerabilities in group settings where they return to the population each week are high. Environments for group therapy need to be secure, supportive and psychologically safe and there is little evidence to suggest that most women's prisons in Australia, particularly maximum security institutions, currently provide such an environment. In light of the above, evidence from a key informant in NSW concerning group sexual abuse sessions conducted as part of a TAFE course for women prisoners entitled "Child Studies: Understanding

Children" is particularly disturbing. In fact this informant suggested that most of the women enrolled in this course, run by the education officer at Mulawa, refused to participate in these sessions.

Finally, group counselling in the drug and alcohol context must also be seen in the context of a longstanding institutional antipathy to the formation of groups of any kind among inmates and the threats to discipline and security such groups are perceived to represent[19].

As Hampton has argued:

> "[G]roups have a tendency to become political when they perceive the inequities in their treatment... groups are not seen as conducive to the only thing that really matters - the good order and management of the jail" (1993:105).

(iii) Therapeutic Communities

Therapeutic communities consist of residential programs which attempt to provide a structured secure environment where drug users can develop social, educational, economic, occupational skills The content of such programs vary enormously and emphasis can range from punitive to highly supportive. Primary treatment approaches typically consist of individual and group therapy and psychotherapy, remedial and formal education classes, residential domestic and work duties. Therapy is situated within the context of a social community with defined boundaries and within this community considerable pressure is exerted on individuals by their peers. Therapeutic communities generally employ a reward system by which participants "earn" privileges and elevate their status within the community by complying with the rules. As Mattick and Hall have recently pointed out, while therapeutic community approaches can be located on a continuum in relation to structure and rules, in recent years there has been a shift away from excessive confrontation and humiliating punishments (1993:xiii).

Successful treatment outcomes are generally defined in terms of a drug free lifestyle, increased economic productivity and reduced anti-social behaviour. The results of lengthy evaluations conducted of both the DARP and TOPS studies in the U.S. suggest significant improvements in immediate and long term outcomes, including a decline in drug use and criminality and an increase in employment and education levels (e.g. Simpson and Sells, 1982; Simpson, 1986; Hubbard et al., 1989). Length of time in treatment has been identified as a critical predictor of treatment outcome for therapuetic communities (DeLeon et al., 1982; DeLeon, 1984; Anglin and Hser, 1990a). In general, this research suggests that therapeutic communities may be suitable as a form of intervention for illicit users with high levels of harm associated with their drug use, including criminal activity. As such, they may be particularly apposite for the target population.

As Mattick and Hall have recently summarized in the Australian context:

> "Therapeutic communities offer an effective form of treatment for a small proportion of drug users who find them acceptable. These drug users will be

those who suffer the more severe consequences of the harm associated with their drug use, criminal activity and social disadvantage" (1993:51).

An increasing body of research suggests that within the correctional setting, the therapeutic community approach can be effective in reducing post-release drug use and criminality for clients (Wexler et al., 1985). Compared to controls, therapeutic community clients tend to evidence fewer arrests, a longer mean time to arrest and a higher incidence of positive parole discharges (e.g. Wexler et al., 1992; Field, 1992). In addition to length of time in treatment, critical components of program efficacy in the correctional context include support of the prison administration, adequately trained and supervised staff and separate living space and therapeutic areas (Lipton et al., 1992).

Despite the fact that the therapeutic community is the most evaluated treatment intervention in the correctional setting, little is known about its efficacy in relation to women inmates. While none of the jurisdictions contacted currently maintained an institutionally based therapeutic community, until recently Victoria operated a four month residential treatment program for 18 women. Anecdotal information suggests that women prisoners under-utilized this service and indeed, during its operation the unit rarely housed more than an average of six women. Among the possible factors that may have contributed to this program's demise were its physical location within a maximum security male prison and a lack of follow up components once women were released back into the general prison population or to the community. One key informant even suggested that women prisoners rejected the service because of its lack of focus on structural issues and the priority accorded compulsory experiential groups or, as she put it, "navel-gazing".

2.3 Methadone Maintenance

Although a range of treatment philosophies undergird the provision of methadone, most programs offer the synthetic narcotic with a goal of permitting the user to live a heroin free-life (e.g. Dole and Nyswander, 1967). Unlike the United States, doseage levels in Australia vary in accordance with individual medical practitioners and a recent estimate indicates that more than 10,000 persons are enrolled in methadone programs nationally (Mattick and Hall, 1993:22). Almost eighty percent of clients are located in NSW which currently has 7,882 persons enrolled in methadone programs, 5.7% of whom are prison inmates (NSW Drug and Alcohol Directorate, 1994).

The extent to which methadone maintenance succeeds in reducing drug use and criminality in the long term is debatable although considerable evidence indicates its effectiveness in reducing drug use and criminality during treatment (Dole et al., 1969; Anglin and McGlothlin, 1984,1985; Ball et al., 1987; Anglin et al., 1988; Hser et al., 1988; Ball and Ross, 1991).[20] Although research suggests that doseage levels may be related to treatment outcome with low-doseage programs in general experiencing higher rates of attrition than medium to high-doseage programs (e.g. Hargreaves, 1983; McGlothlin and Anglin, 1981; Fisher and Anglin, 1987; Ball and Ross, 1991), in recent years the original 'blockade' model has waned in popularity in Australia (Mattick and Hall, 1993:21).

Believed to be one of only two such programs in the world[21], a methadone program has been in operation in selected NSW prisons since 1986. Although the original aim of the program was to reduce the recidivism of drug-related property offenders, its goals have since expanded to include "the continuation of community-based treatment" and "the prevention of HIV and hepatitis in prison" (Hall et al., 1993b:197)[22]. While there is no evidence that the program has reduced post-release recidivism or HIV risk-taking behaviour, this may be due to a paucity of research and methodological problems with existing research (Hall et al., 1993b). Since July 1990 the program has been administered by the Corrections Health Service (hereafter CHS), resulting in "predictable consequences for inter-departmental rivalry and non-cooperation" between health and custodial agents (Hall et al., 1993b:197).

This division of labour has also produced a number of anomalies. In addition to being subject to urinalysis for the purposes of treatment monitoring by the CHS, methadone recipients are also exposed to the urinalysis program conducted by the Department of Corrective Services (hereafter DCS) which aims to detect and punish individual drug use. Unlike the CHS program, the DCS imposes a regime of disciplinary punishments for "offences" associated with "dirty" urines. As patients of the CHS, methadone clients have also been deprived of access to drug and alcohol counselling services provided by the the DCS Drug and Alcohol Workers in Prison Program[23].

As Hall and colleagues have pointed out, the failure to provide methadone recipients counselling represents a major departure from the most effective form of methadone maintenance therapy (i.e. high daily doses in conjunction with a comprehensive treatment program) which may seriously compromise the effectiveness of the program (1993b:198). As they conclude, the NSW experience suggests that the effectiveness of prison-based methadone programs "... may be impaired by restrictions on its operation that are prompted by security concerns, lack of understanding of its rationale, the hostility to methadone of some prison officers and other prison staff, and by the lack of access to counselling services by prisoners who are on the methadone programme" (1993b:200).

In 1993, 452 inmates or 7% of all prisoners were receiving methadone in NSW prisons (NSW Drug and Alcohol Directorate 1994).[24] National statistics indicate that women comprise some 38% of methadone patients (NSW Drug and Alcohol Directorate, 1994). In July 1994, 80 women or 26% of the female inmate population were enrolled in the methadone program (Jeffries, personal communication, 1994). All of these women are confined to Mulawa, a maximum security institution. While women constitute less than 5% of the NSW prison population, they represent 18% of prisoners maintained on methadone. Although women prisoners on methadone are over-represented relative to their representation within the prison system, they remain under-represented in relation to the gender composition of methadone clients nationally. Given the higher incidence of intravenous drug use among female prisoners and that fact that at least 66% of women in prison are estimated to be heroin users (WIPTF, 1985), this study found no evidence to suggest either that methadone is being used as a form of social control in NSW or that women are deliberately injuring themselves in order to be accepted into the program (cf. Waller, 1993). In fact there is some evidence to suggest an unmet demand for greater female participation in the program.

In contrast to NSW, Victoria's restricted prison methadone program aims to provide a bridging function by allowing inmates on remand or serving sentences of less than three

months who are enrolled in community methadone programs to be maintained in prison. Denton (1994) found high levels of dissatisfaction among women prisoners with this policy. In particular, many women were critical of the way in which they were withdrawn from methadone. Indeed the women's accounts of rapid reductions in doseage over short periods of time - e.g. from 95mls to nothing in three weeks -are disturbing and do not appear to conform to established practice in the area.[25] South Australia also has a limited methadone program for approximately 24 inmates. This program is confined to metropolitan institutions and participation is restricted to prisoners prescribed methadone immediately prior to reception, pregnant women and HIV positive inmates. While HIV positive inmates are reportedly permitted to remain on methadone indefinately, all other clients are reduced and withdrawn (Caroll and Bear, 1993).

Finally, it is important to note that while there has been an increase in the number of places available on methadone programs in the general community over the past four years, there has been no expansion in prison-based programs. In NSW, where the number of prisoners in the methadone program currently exceeds the quota of 500, demand far outweighs supply and a substantial waiting list exists for the program at any given time. This is despite a significant increase in the prison population from a daily average of 4358 inmates in 1988-89 to 6392 in 1993 (Eyland, 1993), with further increases anticipated as a result of the 1989 NSW Sentencing Act (Gorta and Eyland, 1990).

III GAPS IN RESEARCH, POLICY AND SERVICES

3.0 Gender-Specific Barriers to Treatment

The literature indicates the existence of a number of gender-specific barriers to treatment which are believed to affect the likelihood of women drug users seeking and remaining in treatment. Research suggests that increased services relating to children, health and legal problems and sexual and physical assault issues may improve access and treatment outcomes for women clients (e.g. Marsh, 1982; Russell and Wilsnack, 1991; Reed, 1985; 1991). Indeed, a recent study in Victoria identified childcare as "the single most significant and supported issue" for women with drug and alcohol problems (Ribton-Turner and McDonald, 1992:35). The support of a partner has also been identified in several studies as associated with increased retention and positive treatment outcomes for women (Eldred and Washington, 1976; Tucker, 1979; Nurco et al., 1982).

(i) Mixed Sex Programs Versus Specialist Women's Services

A growing body of evidence suggests that existing mixed sex programs, which have been designed to meet the needs of men, often ignore the needs of women and provide an environment which is hostile or unresponsive to their needs. Traditional treatment programming has been designed with "male, cognitive, emotional and interpersonal styles" in mind (Reed, 1985:52). Such programming is believed to reinforce gender role socialization by sustaining and reinscribing popular notions of women as passive and dependent (e.g. Levy and Doyle, 1974; Murphy and Rollins, 1980) and in some instances provides an institutional setting for the sexual and physical harassment of women (e.g. Cuskey et al., 1979; Boland

and Gilmore, 1984). As Boland and Gilmore (1984) have noted in the context of the Pinaroo House Women's Programme in Victoria:

> "In the words of the women themselves, coming into a traditional male and female treatment setting means feeling nervous, scared, vulnerable and threatened. It means not knowing where to go and being subjected to sexual harassment."

Traditional mixed sex services have also been reluctant to acknowledge the responsibility of women for dependent children (e.g. Gerstein et al., 1979; Moise et al., 1982). Legitimate concerns in relation to the potential loss of child custody may serve to prevent women from acknowledging their drug problems and seeking and remaining in treatment (Reed, 1985). Simultaneously however, the literature also identifies maternal responsibilities and concerns as major factors which may ecourage women to seek treatment. Pregnancy is believed in many instances to provide a "window of opportunity" in which concerns for the well-being of the foetus motivate women to seek treatment (e.g. Rosenbaum, 1979, 1981). Similarly, concerns in relation to potential loss of custody of existing children may also encourage women to seek assistance (Rosenbaum and Murphy, 1991; Reed, 1985; Vandor et al., 1991). However, while the extent to which maternal responsibilities serve to either encourage or preclude women from entering treatment varies, there is some evidence to suggest that on entering treatment, the failure of programs to address women's concerns in relation to their children often serves to exacerbate the very emotions which sustain drug use (Rosenbaum, 1979). As Copeland et al. have argued:

> "The magnification of existing feelings of guilt, shame and failure surrounding their maternal role, if left unaddressed, may negatively affect treatment outcome as women use alcohol or other drugs to cope with these intense emotions after discharge" (1993:16).

The high reported incidence of sexual and physical abuse among women drug users (e.g. Miller et al., 1987; Hagan, 1988; Russell et al., 1988; Hurley, 1991; Reed, 1991; Russell and Wilsnack, 1991) indicates a further failure on the part of traditional mixed sex programs to deal with the special needs of women. The presence of male staff and clients may impede the treatment of women with histories of sexual and physical abuse by inhibiting the full and frank disclosure of such experiences. If indeed such abuse histories are relevant to the woman's drug use, failure to resolve these underlying issues may precipitate relapse (Rohsenow et al., 1988; Young, 1990). Some evidence also suggests that the needs of lesbian women have also been neglected by traditional mixed sex programming. The risk of homophobia and male sexual harassment are compounded in many instances by insensitivity and a lack of understanding of lesbian sexuality.

Traditional mixed sex programs typically employ a peer group model which emphasizes confrontation and the breakdown of resistance or "denial". Undeniably male oriented, such a model has its roots in treatment interventions based on the cultural norms and experiences of mostly white, middle class male drug users. This model is also characterized by an exclusive focus on arresting addiction or attaining sobriety, at least initially, at the expense of other problems. For women who are unable to so readily absolve themselves of their responsibilities, the need to address structural issues such as the need for accomodation and

food for themselves and their children may mean that they do not seek or remain in treatment. Moreover, as Reed (1985) has argued, the use of confrontational and confessional modes, which are more likely to exacerbate the incidence of guilt and depression, are not appropriate and may in fact be counterproductive in the development of models of services provision for women.

By comparison, specialist women's programs are believed to facilitate more effective drug treatment for women by providing a physically and emotionally safe supportive environment which recognizes women's needs. A recent evaluation of a specialist women's service in NSW concluded that, in comparison with two mixed sex programs, this service was "better able to provide both individual and group therapy according to the specific needs of each woman" (Copeland et al., 1993:90). Specifically, this service exhibited considerable success in attracting and retaining groups such as women with dependent children, women with histories of sexual abuse and maternal substance abuse and lesbians, whom the literature suggests are not well served by traditional mixed sex programs. While this study found that the specialist women's service was significantly more likely to increase the retention rates of such women, there were no significant differences between the groups in relation to treatment outcome at six months follow up (Copeland et al., 1993).

While this research clearly indicates that specialist women's services may be efficacious in reaching groups of women who otherwise would not be in treatment or groups of women with retention problems in traditional settings, it is unclear whether specialist women's services are the appropriate or desired model for all women. Indeed, recent survey research conducted in Victoria suggests that while only 12.8% of women treatment clients indicated that male involvement in programs would inhibit their treatment, 21.3% of women surveyed indicated that being part of an "all female environment" would inhibit their treatment (Sirilas, 1992:5). For these women, treatment in an all female environment was superceded only by "difficulties with childcare" (25.5%) as a factor which would prevent them from continuing with on-going treatment (Sirilas, 1992:5; see also Ribton-Turner and McDonald, 1992). However, as Copeland et al. have pointed out, it is important that efforts continue to develop and evaluate specialist women's services:

> "The feminist theory and clinical lore which have informed decisions about the provision of specialist women's alcohol and other drug treatment services have not been empirically tested in women who are severely dependent on a range of phsycoactive substances and suffer from a plethora of complex attendant problems" (1993:100).

Finally, there is the issue of the applicability of specialist women's services within the prison context. Some will inevitably argue that given that all Australian prisons are sex-segregated, existing programs in women's prisons can be seen as delivering specialist women's services. However, to the extent that drug and alcohol services have been provided for women in prison to date, such services appear to have been largely based on traditional mixed-sex program models incorporating a disease model of addiction, including recognition of abstinence as the only legitimate program goal and a reliance on confrontational therapies and the 12 step approach. The evaluation research described above (Copeland et al., 1993) suggests that the ability of specialist women's services to attract and retain in treatment

groups of women whose needs have been unmet in the context of traditional programs holds promising implications for treatment interventions in relation to the target population.

(ii) Sexual and Physical Assault Issues

Recent research suggests that as many as 75% of women in drug treatment have histories of sexual and physical abuse (e.g. see Miller et al., 1987; Hagan, 1988; Russell et al., 1988; Hurley, 1991; Reed, 1991; Russell and Wilsnack, 1991). The failure of traditional mixed sex programs to deal with these issues has been repeatedly identified and commented on at length in the literature. However, while most researchers are wary about making causal connections between sexual and physical abuse and drug abuse, clinicians and other service providers have demonstrated little reluctance to attribute causality (e.g. see Greenleaf, 1989; Hamilton, 1993:363).

Clinicians and other treatment personnel are increasingly aware of the salience of these issues. For example, a recent survey of selected Drug Services Victoria Staff found that - in response to the question "The most notable things about women in treatment are ...?" staff indicated a history of sexual assault or abuse and a history of physical abuse as major themes. The personnel surveyed in this study also identified the need for training in sexual assault and incest counselling and the need for understanding sexual abuse as pre-requisites to more effective work with female clients (McDonald, 1992:4,9,11).

However, given the increased recognition and emphasis on sexual and physical abuse issues in treatment programming, there exists a potential danger of counsellors and other program staff without sufficient training or expertise attempting to deal with these issues in a confrontational manner. As Copeland et al. have pointed out, "The ways in which problems such as sexual assault and psychiatric co-morbidity are managed requires clarification ... Counsellors who do not have professional training in the management of sexual assault issues should not attempt to address such concerns (Copeland et al., 1993:96; see also Russell and Wilsnack, 1991:67-68).

It is also important to note that to date most research has failed to solicit the perceptions of women drug users themselves in relation to their treatment needs. Recent research which sought the views of women in the general population found an apparent contradiction between the priority given to these issues in existing programs and female clients' perceptions of their needs. In response to the question "In any on-going treatment, what areas do you think you need to work on?", a survey of 47 consecutive women clients in Victoria found that only 22.9% of women in detoxification and 8.3% of women in a methadone program believed that sexual abuse issues "needed work". In comparison to the other issues identified by the women, issues in relation to sexual assault, domestic violence and women's health issues were deemed to need the least amount of work. The areas selected by women as areas they most needed to work on were relapse prevention (72.3% overall); dealing with anxiety (70.2% overall); stress management (61.7% overall); overcoming boredom (59.6% overall); assertiveness training (46.8%); and anger management (44.7%) (Sirilas, 1992:7).

Although there has been no systematic research conducted in relation to women in prison in Australia, in the United States, 41% of women in prison and almost a third (30.5%) of women imprisoned for drug offences reported a history of physical and/or sexual abuse with an

estimated 22% of women reporting sexual abuse before the age of 18. However, female drug offenders in the U.S. are less than likely than women imprisoned for other types of offences, including violent offences (41.0%), property offences (36.0%), public order offences (39.9%) and all groups combined (41.0%), to report such histories (Bureau of Justice Statistics, 1991).

In Australia, estimates as to the prevalence of sexual and physical abuse among women in prison suggest that between 50% and 85% of the population has been sexually and/or physically abused (e.g. WIPTF, 1985; George, 1988; Easteal, 1992, 1994; Denton, 1994). Most recently, Denton (1994) found that among a sample of female prisoners in Victoria, 64% reported a history of physical and/or sexual abuse. Interestingly, while drug using women were more likey to report a history of physical abuse (74%) compared to 36% of non drug users, non drug users were more likely to have been sexually abused (55%) than drug users (35%) (Denton, 1994:35-36).

Notwithstanding the increasingly routine incorporation of sexual and physical assault counselling into drug treatment programming for women, research to date has failed to establish the nature of the relationship between sexual/physical abuse and drug use and related lawbreaking. While a growing body of research confirms the existence of a strong correlation between childhood victimization and adult lawbreaking (e.g. Miller, 1986; Widom, 1989; 1990; Gilfus, 1992; Daly, 1992; Maher, forthcoming), this linkage is neither direct or unmediated. The considerable 'black box' that currently exists between women's experiences of victimization and subsequent lawbreaking (Maher, forthcoming) indicates a clear need both for further research and greater consultation in relation to what women drug users believe to be their treatment needs and specifically, in relation to sexual and physical abuse issues.

3.1 Prison-Specific Barriers to Treatment

> "There are a variety of women in the prison population who seek 'drug' treatment: women in drug withdrawal, women experiencing drug psychosis, women withdrawing from methadone, women in psychological drug withdrawal, women who are suffering prison stress created by separation from their children, women with legal problems and pending court cases, women with major psychiatric disorders, women suffering reactive depression, women suffering the effects of physical or sexual abuse, women with medical or surgical conditions and women who use drugs for recreational purposes" (Denton, 1994:51).

As Denton has pointed out, the target population evidences an eclectic mixture of needs, demands and motivating factors in relation to treatment. To date there has been little research overseas and none in Australia which seeks to evaluate the effectiveness of treatment interventions for this group. In the U.S., a recent "state-of-the art" review which attempts to "bring together available research knowledge, program concepts and clinical insights regarding drug abuse treatment of incarcerated, drug-dependent offenders" (Tims and Leukefeld, 1992:5) all but ignores women. Closer to home however, the absence of formal evaluations does not appear to have hampered the NSW Department of Corrective Services which in 1990 claimed simply that "All [drug and alcohol] programs are effective" (cited in Hampton, 1993:105).

The following sections seek to identify barriers to treatment which are specific to the prison or custodial setting, some of which are gender specific, and all of which hold implications for the target population.

(i) Lack of Systematic Screening and Assessment Procedures

Recent research suggests that more than 50% of incarcerated regular-heavy drug users do not receive any drug treatment at all during their imprisonment (Kevin, 1993). Effective screening procedures are a pre-requisiste to any successful treatment intervention. In addition to identifying inmates with drug problems, screening provides an initial point of contact for introducing inmates to available treatment options either orally or by way of targetted literature. Despite the fact that reception into prison would appear to be the most suitable point at which to establish such contact, there is little evidence to indicate that this in fact actually occurs. In most states, drug and alcohol screening upon reception to prison is undertaken as part of a more general screening process primarily concerned with other priorities such as suicide prevention.

In NSW, a recent review of corrections' drug and alcohol services found that the reception screening procedure administered by the CHS at the principal metropolitan reception prison for males, failed to systematically refer inmates to the Drug and Alcohol Service (MSJ Keys Young, 1992). In fact, only one inmate in a recent study reported being referred to the Drug and Alcohol Service by the CHS (Kevin, 1993). This study also found that a full 10% of potential clients in this sample who did not use the service, were unaware that the service even existed (Kevin, 1993). Even where inmates are referred to the Drug and Alcohol Service, the lack of any standardised assessment protocol or procedure tends to produce a series of highly idiosyncratic partial assessments that follow the prisoner throughout the system (MSJ Keys Young, 1992).

Moreover, a recent inquiry into suicides and self harm in NSW prisons found that while women prisoners at Mulawa are ostensibly screened upon reception, no written records are kept of this process (Waller, 1993). As recommended by the external consultants who reviewed the NSW program, drug and alcohol assessment should consist of a series of staged screening and assessment steps which utilize standardized instruments and procedures (MSJ Keys Young, 1992). Such assessments should be initiated in women's prisons as a matter of priority.

Finally, evidence from key informants suggests that in order to be effective, screening and assessment proceedures may need to be tailored to the target population and sensitive to the impact of historical and cultural factors in shaping particular institutional relations. Although none of the young women interviewed for this project who had been in juvenile justice custody in NSW reported being assessed for or receiving assistance with drug and alcohol problems while in detention, even where such mechanisms are in place, other factors may serve to impede identification and intervention. As Karen, a 17 year old heroin user and street-level sexworker in Kings Cross told me:

> "The first time I was 13. I was really scared. I had all these images of back episodes of 'Prisoner' but when I got there I knew a lot of girls so it was more like a reunion. [Did anyone there ever talk to you about your drug and alcohol

> problems?] No, but I wouldn't have said anything anyway, you just wouldn't in front of a screw. You get fucked over too much. Even though its more acceptable now, girls are still secretive about if they are using. [Why do you think its more acceptable now?] 'Caus they have all this stuff about like if you've been abused and that, like that's why a lotta girls are using. But at the time you just don't want to deal with that kind of stuff. It's not going to help you in there and when you get back out here, who gives a shit, probably half the girls I know ... like Jasmine [Lodge] you know, there was nothing to stop her from dying."

As the above quotation indicates, there are signs that for some young women at least, things may be beginning to change in NSW detention centres. Indeed, statistics from the NSW Department of Juvenile Justice identified 17 out of the 21 young women currently detained at its new girls facility as part of the caseload of the Drug and Alcohol Counsellor (Barton, 1994).

(ii) Effect of Negative Prison Environment on Women

A considerable literature attests to the fact that prison may reinforce existing negative attitudes, compound low self esteem and exacerbate the sense of degregadation, powerlessness and alienation many women drug users already experience. In addition to their double deviance by virtue of transgression of legal and gender norms, incarcerated women "often fall victim to inwardly believing that their actions are totally their own fault, not influenced by any external social conditions" (Ramsey, 1980:361). It has also been suggested that the costs of imprisonment for women are much higher than those incurred by men by virtue of the close association between family, self identity and social status for many women. Cut off from their families, women prisoners may experience a loss of identity and feelings of emotional isolation (Heidensohn, 1985). Moreover, the impact of the institutional setting is gender differentiated with women more acutely experiencing the loss of personal identifiers such as clothing, jewellery and cosmetics[26]. As Ramsey has argued, "[I]ncarceration creates a greater sense of personal disorientation, alienation, degradation, and powerlessness in female drug offenders than in male drug offenders" (1980:362). As Mandy, a 33 year old former heroin user and ex-prisoner who now works in the drug treatment field saw it:

> "The prison system as it is now is masculine. It encourages and sustains dependency right, so you've got 80% of women who are heroin addicts so you're putting them in an environment where they're dependent. 70% are victims of incest, rape and/or domestic violence, 50% are primary care givers of children. So they're taken out of society and placed in an institution that caters to their dependency and avoidance - all of that caus' there's no real input for dealing with this kind of stuff. Like sexual assault - there's nothing. The fact that women only make up 5% of the prison system - it doesn't warrant the financial cost. Men get the special care unit, men get this and that, they get this new beaut young offenders gaol at Parklea and women get nothing."

Moreover, as Heidensohn has pointed out, "Violence and disturbance seem more prevalent in female institutions" (1985:82). This is supported by recent statistics from NSW which

indicate that Mulawa has the third highest rate of assaults on both officers and inmates with 17.3 assaults on officers per 100 daily average inmayte population and 23.6 assaults on inmates per 100 daily average inmate population (Thompson, 1994). Self harm has also long been acknowledged to be more widespread and to pose greater problems for women's prisons (Heidenshon, 1985:73-74). Overseas research indicates that self mutilation is more common among women, particularly adolescent females, than men in prison settings (Lloyd, 1990).

Australian statistics confirm that women are over-represented among suicides, parasuicides and incidents of self harm in prison. While they constitute less than 5% of the prison population, it has been suggested that women may account for as much as 25% of prison suicides (Pritchard, 1988). The rate of suicide for women in prison is believed to be four times in excess of the rate for women in the community (Fitzroy Legal Service, 1988:27).[27] At least four of the seven women who committed suicide in Mulawa between 1970 and 1988 were heroin users. More recently, anecdotal evidence suggests there have been two drug-related deaths of women in prison in NSW and at least four drug-related deaths of women released from prison in 1993-1994.[28]

Research compiled for the Royal Commission into Aboriginal Deaths in Custody found that despite their under-representation among offender populations, 18% of incidents of self inflicted harm reported over a six month period in 1989 involved women, with 70% of these incidents occuring inside women's prisons (Fleming et al., 1990). More recently, official data from the NSW DCS indicates that the incidence of self harm among female prisoners has increased dramatically. In 1991 (when reporting procedures were changed), incidents at Mulawa accounted for 13% of all self harm in NSW prisons, compared to 35% of the total in 1994. In fact the official figure of 73 incidents for the first five months of 1994 is equivalent to the previous years' total (NSW Department of Corrective Services, 1993-4). Outside estimates are much higher, suggesting that as many as 112 cases of self inflicted injury may have occurred at Mulawa between January and June 1994 (*Sydney Morning Herald*, 23 April 1994; 27 July 1994).

In 1993 a government committee charged with inquiring into suicides and self harm in NSW prisons recommended that a crisis support unit be established at Mulawa by the end of the year to manage "at risk" women and women with histories of self harm (Waller, 1993). That by mid-1994, this unit was still not in existence lends support to Lamont's suggestion that the most recent spate of what she describes as "attempted suicides" is "in part attributable to the policies of Corrective Services of NSW" (Lamont, 1994:2).[29] This was confirmed by Debbie, a 29 year old woman with a long history of heroin and other drug use who was recently released from Mulawa:

> "The women who are mutilating, it is gross neglect on the part of the prison system and the medical staff. They should be accountable for it and that is because these women, anybody who cuts up, you're talking about like severe emotional and psychological sort of problems. Quite often women have been sexually abused. Its a way of coping and realizing and being able to see the hurt. I hurt inside and I've got to see whats hurting so it will stop. Like they're crying out for someone to hear them."

Another key informant, Leanne, a 27 year old women with a lengthy history of heroin use, drug-related imprisonment and self harm explained the situation as follows:

> "If you ask me, it's the situation at Mulawa. Its the same reason as women use anything they can get their hands on. Like being locked in, only getting one phone call a week. C'mon, my youngest two, they can't even read. The phone is my only hope ... Things like that, you know, that you should have a right to, that's how bad the situation is. Then you get girls getting involved with the screws, like if you scratch my back, I'll scratch yours, that kind of shit. And now there's more males [officers] than females. It's wrong. Its different at Norma's [the minimum security facility for women in NSW]."

Similarly, although the sample of girls is to small to provide a gender analysis, Zibert et al. (1994) also found a disturbingly high rate of attempted suicide among incarcerated young offenders, with 21.9% reporting ever having attempted suicide. As Dimity, a 16 year old Koori 'street kid' from Sydney's Kings Cross told me:

> "I used to do it caus' I couldn't use to cry and if I cut myself it hurt so I could cry. Mainly I did it when I was heaps hurt and I couldn't cry."

The high incidence of suicide and self-harm among the target population attests to both the differential impact of imprisonment on women and what has been called the "dsyfunctional culture of women's prisons" (Easteal, 1994). However, such cultures are by no means monolithic and exhibit considerable variation both between prisons (e.g. Mulawa and Norma Parker Centre in NSW) and between states. Indeed, recent research conducted in Victoria suggests that the incidence of self-harm among women prisoners cannot, as the NSW DCS would have it, simply be attributed to psychiatric or psychological dsyfunction in the female prison population or the indiscriminate use of "pills" by women prisoners. Despite the fact that a total of 10 women (18%) in her study were identified as either currently or previously suffering from a dual diagnosis (severe mental disorder and a substance dependence disorder)[30], Denton (1994) found the incidence of self-mutilation to be rare in Victoria with only two women, one of whom was a drug user, reporting that they had engaged in this behavior (1994:36).

(iii) Punitive Attitudes Towards Women Prisoners

Readings of women's crime and drug use, in both academic and popular discourse, are filtered through the lens of gender deviance. The disciplinary regime that characterizes women's prisons continues to be inexorably bound up with notions of women's "proper" place in society. As Carlen has noted, the "general motto" in relation to the management of female prisoners has been to "discipline, medicalise and feminise" (1983:18). In a critical review of the management techniques typically employed in NSW women's prisons, the WIPTF recognized the treatment of women as "errant children" as "demeaning and counter-productive" (WIPTF, 1985:46). The report was critical of general practices such as the use of the term "girls" to refer to women inmates and associated phrases such as "playing up" and denounced specific practices such as the keeping of "naughty cards" to record alleged disciplinary infractions and the punishment "early beds" (1985:46).

Many of these practices and the attitudes that serve to sustain them remain. Indeed, key informants reported the widespread use of informal and extra-legal punishment in the form of "tipping". Custodial staff routinely "tip" inmates for trivial and unproven "offences" such as "rudeness to officers", being unable to provide a urine specimen within a two hour period and even for overdosing on drugs. Women who are "tipped" are isolated and placed in what is known as the "tipped" wing of Conlon, sometimes for months at a time. These women forgo the usual gaol "priveleges", which include contact visits, employment and regular "buy ups" and are locked in their cells at 4.00pm. As a serving female prisoner recently claimed, women in prison in NSW continue to be treated as "rebellious children":

> "The problem is that Corrective Services do not see their job as one of containment and care of [women] prisoners. The view still prevalent is that most [women] prisoners are incorrigible and should be at least harassed, ignored or punished severely for trivial offences" (Lamont, 1994:2).

(iv) Over-Reliance on Licit Medications

Historically, women's prisons have exhibited a near universal tendency to rely on the passivity induced by the overprescription of psychotrophic and hypnotic drugs for the management and control of female prisoners (e.g. Benn, 1983; Bacon, 1983). Again, there is little to suggest that this situation has altered radically, if at all. As Easteal has recently argued:

> "If the female inmate begins to feel (anxiety, anger, depression) and either expresses it in an institutionally inappropriate fashion or else seeks assistance, the overwhelming response by the institution is to medicate her. The current research did not find substantive evidence of much change in what has been described by others as the indiscriminate use of prescription drugs (1994:56)."

As Hampton's recent study suggests, the use of prescription drugs is almost compulsory in NSW women's prisons. One of the women Hampton interviewed claimed that the police had told the magistrate she was suicidal in order to stop her getting bail. This woman was subsequently refused bail and taken to Mulawa where she was placed in the psychiatric unit:

> "They tried to give me medication there but I refused it. I saw the psychiatrist the day after I was taken there, spoke for all of about ten minutes and then went back to the cells ... About two days later the psychiatrist called me up again, spent another five minutes with me and then ordered medication and asked me what anti-depressant did I want to take. I didn't want them but I got a prescription anyway" (cited in Hampton 1993:106).

The current high level of pill useage at Mulawa was confirmed by a number of sources. As Debbie told me:

> "The pills situation in Mulawa is absolutely astronomical - half of Mulawa are just off their faces, absolutely wiped out on pills. There's always been a very large pill problem there - mainly serapax, like all downers, although you are starting to get the younger population, like the street kids, using avils. As to

how they're getting it in, some of its on the visits but the amount that's in there, its not just going in there on visits."

Finally, as Hampton herself has argued, drugs - both licit and illicit - clearly continue to condition the nature of interactions within women's prisons.

> "Interaction with other inmates, at least initially, seems largely dependent on whether or not you are getting methadone or other illegal drugs. If you are, life can be very difficult or even dangerous. If you are big enough or tough enough these activities can win you undeserved friends and allegiances ... If you are not big or tough, then it's simply a matter of when and to whom you give at least some of your drugs, because they are going to be requested with enough force to make any resistance laughable (1993:39)."

(v) Lack of Focus on Structural Issues

Research conducted in North America indicates that women entering treatment have fewer economic resources than their male counterparts (Moise et al., 1982) and many have little or no experience of formal labour force participation (Reid and Liebson, 1981). By focussing on the vocational and employment prospects of males at the expense of women, treatment programs have served to sustain the marginal economic position of women drug users (Reed, 1985:31).

Similarly, in prison, vocational training for women has tended to reinforce their traditional labour market positioning in occupations characterized by sex segmentation and low wages (e.g. see WIPTF, 1985). Recent research by Easteal (1992; 1994) confirms that little has changed. For the most part, the employment that is available within women's prisons remains limited to "traditionally 'female' occupations such as laundering, sewing and other non-industry jobs that are domestic in nature such as cooking and sweeping" (Easteal, 1994:56; see also Hampton, 1993:62-65).[31] Moreover, as Easteal has pointed out, while the official wage of prisoners nationally varies between $50 and $60 a week, the salaries of the 56 female inmates she interviewed ranged between $9 and $35 a week for unskilled work which the women themselves described as "mundane" and "mindless" (1994:56). As Hampton has pointed out:

> "Work that matters to no-one is worse than no work at all. Doing useless or low quality work only reinforces the worthlessness a prisoner feels. It hardly engenders any desire to engage in outside work, and makes the time pass so much more slowly" (1993:62)."

Chronic use of illicit drugs by women offenders is usually part of a complex multi-problem, high-risk lifestyle. This population typically has little education, no marketable skills, few legal employment opportunities and is often homeless. They are at high risk of violence and chronic social and health problems, including gynaecological problems, HIV/AIDS and hepatitis. There is little to suggest that the profile of 'drug-dependent' women in prison developed by the NSW WIPTF has changed - i.e. the majority are "young, working class and caught up in a cycle of poverty, unemployment and homelessness" (1985:82). Similarly, recent research by the NSW Department of Juvenile Justice identified 72% of young women

in custody as having at some stage appeared before the courts in relation to offences which could be categorised as "survival strategies" (Cain, 1994a).

Treatment interventions which seek to target these populations must contend with these problems if they seek to effect meaningful long-term changes. Drug treatment services for women and girls in custody clearly need to be developed in conjunction with services directed at meeting their educational, vocational training and employment needs. As Ramsey has argued:

> "[T]herapeutic programming for female drug offenders must not utilize the humiliation tactics of traditional drug treatment programs to sensitize women to their errors nor should it use menial, sexually stereotyped tasks as learning experiences ... In the final analysis, therapeutic programs for female drug offenders must be based on an approach that goes beyond placing responsibility on the individual for her problems. They should also focus on the social and political causes of female drug abuse (Ramsey, 1980:367)."

(vi) Access to Programs and Services

A recent study in NSW found that 59% of a sample of prisoners interviewed upon reception felt that their drug use had caused them problems in the previous 12 months and 46% stated that they were dependent on alcohol and/or other drugs. Almost half the sample indicated that they would like drug treatment while in prison (Stathis et al., 1991). However, Kevin (1993) reports that despite the introduction of D&A Workers in all NSW gaols, only 36% of inmates in a recent representative sample reported that a Drug and Alcohol worker was present at their reception meeting. More than half the sample had not received any form of drug and alcohol assessment. Of the 42% who reported having been assessed, 22% were assessed by the Corrections Health Service[32]. Only 33% (N=58) of this sample actually used the D&A Service during their sentence and of those, 28% reported problems in accessing the service. The most frequently cited factor was that the D&A Worker was too busy, followed by a lack of cooperation from custodial staff. Of those inmates who had used the service and had been transferred to another prison during their sentence, 29% reported that their program had been interrupted (Kevin, 1993).

Evidence from NSW also indicates that the criteria currently employed for inclusion in the prison methadone program may serve as a powerful dis-incentive to prisoners insofar as participation in the program is confined to inmates in maximum and medium security prisons (Hall et al., 1993b). Prisoners who wish to remain on methadone are not only confined to closed (over-crowded) institutions but are denied access to other components of prison programming such as some forms of prison employment, work release programs and other benefits of minimum security institutions such as fewer restrictions and greater access to better visiting conditions. Similarly, anecdotal evidence suggests that the location of the now disbanded residential program for women inmates in Victoria inside a maximum security male prison may have served as a barrier to treatment for some women and contributed to the under-utilization of this facility.

As both Hampton (1993) and Easteal have pointed out, until recently, the deployment of only one drug and alcohol worker at Mulawa, the principal women's prison in NSW (a ratio of

1/300) severely impeded the development of treatment programming for women. However, as Hampton has argued, concerns in relation to the confidentiality of prisoner records may also serve to inhibit women from open and honest participation in prison-based treatment (1993:105). Finally, a number of the key informants who contributed to this project identified the conflict between work and treatment - compounded by the shortage of full time jobs and fierce competetion among the women for work assignments - as a major barrier to participation in drug and alcohol programs. As Mandy told me:

> "They've got two D&A workers in Mulawa who are non-functional. Like they had funding for one D&A worker and they were running groups and getting people in to do groups and that but they were not viable - not just NA and AA but really like, living skills, social skills, role playing - different groups where you can really recognize different things within yourself. Well, it wasn't viable because people couldn't go to these groups because, like the average wage in Mulawa is about $14 a week right, with that $14 you gotta buy cigarettes, toothpaste, shampoo, a can a coke here and there or something like that and um, if they've got no outside financial help, they take time off work, they lose money, so you can't go to this group. They can't be run at night and there's a high percentage of days when you're just locked in anyway, so the majority of women decide not to go because its a **financial choice** - they need to survive as well. So what happened was they stopped the groups and put in another D&A worker. They stopped them because people weren't attending caus' they couldn't attend but they never bothered to stop and think why. And then they used the money for the groups to get another D&A worker, so now you've got 2 D&A workers in Mulawa who are basically not really reaching the people, their client group ... But I know for a fact they wouldn't let me set foot inside a gaol and yet the thing is I could do so much to assist and like, help women and there's no way they would even let me inside the front gate."

3.2 Gaps in Research

While there have been a handful of overseas studies which utilize matched comparison groups, research in relation to treatment effectiveness has been compromised by the lack of random assignment experimental research able to rule out factors such as maturation and regression to the mean in accounting for positive treatment outcomes. This is particularly apparent in relation to treatment interventions for illicit drug users and imprisoned populations and especially in the Australian context where there have been no random assignment control studies in relation to treatment interventions for offender populations.

However, it is equally as important to note that policy and research in both the drug and alcohol and criminal justice arenas have long been dominated by the needs of men and a concern to reduce the consequences of drug and alcohol use by males. For example, Harrison and Belille (1987) suggest that only 8% of subjects in published studies of alcohol treatment were women (see also Jacobson, 1987). Where women are included in research, the data is usually presented as group data or women are too few in number to permit any kind of gender analysis. The great bulk of research and policy in relation to treatment programming and efficacy then, is based on understandings of male drug use and male drug users. This

section seeks to identify some of the most pressing gaps in relation to knowledge concerning drug use among female offender populations.

(i) Patterns of Drug Use Within the Prison Setting

Despite a pervasive commonsense that drug use is endemic inside prisons, little is known about the actual prevalence and patterns of drug use in prison settings. Based in large part on media accounts, reports of drug use in prisons tend to focus on correctional staff and police complicity (Inciardi et al., 1993:11). However, a recent interview study of women prisoners suggests that:

> "Although the entire prison environment is oriented towards the ostensible eradication of these drugs, according to many of the inmates in the sample and the officers, these attempts have been unsuccessful. Almost every interviewee confirmed the presence of illegal drugs (Easteal, 1994:54)."

While this study suggests that illicit drugs, especially "pills", are readily available in women's prisons, it was not specifically concerned with drug use and as such does not attempt to document the specifics of this phenomenon. It is however, reasonable to assume that patterns of drug use within prison environments across Australia will evince considerable variation in accordance with the gender and ethnic composition of the population and institutional features such as whether the setting is a maximum, medium or minimum security facility.

While we know little about these patterns, they are important to document for the nature and level of drug use in prison environments undoubtedly holds implications for prison-based treatment programs. Although much has been written about the effectiveness of implementing drug treatment programs in prisons, we lack information on how the presence of different types of drugs affect treatment interventions. For example, there is some evidence to suggest that illicit benzodiazepine use is increasingly frequent in women's prisons (Easteal, 1992; 1994). Pills are generally held to be cheaper, easier and safer to smuggle into prisons and once inside, easier to distribute and to conceal from authorities (Major, 1993:4). As a key informant currently working within the NSW prison system told me, attempts to control the supply of pills are futile: "The dogs can't sniff them, they [the officers] can't do cavity searches, so as long as a woman has a fanny she has somewhere to store her benzos".

Finally, it has been suggested that drug use within the prison environment promotes the incidence of violence. While the level of violence in NSW prisons increased from a reported 7.7 assaults per 100 prisoners in 1990 to 10 assaults per hundred prisoners in 1993 (Thompson, 1994; see also Sydney Morning Herald, 25 July 1994), this increase is at least partly due to the staggering increase in the prison population as a result of changes to the NSW Sentencing Act in 1989. These changes, which have meant more people sentenced to prison for longer periods (Gorta and Eyland, 1990), have prompted severe overcrowding. The resulting tensions have been exacerbated by a corresponding dimunition in the ratio of staff to prisoners (*Sydney Morning Herald*, 9 May 1994).

(ii) Incidence and Prevalence of Alcohol Use

This paper, in relying heavily on the extant research literature, is also guilty of an over-emphasis on illicit drug use among populations of imprisoned women. However, the available evidence appears to suggest that imprisoned men are more likely to use alcohol and to experience alcohol related problems than are women who tend to report a much higher incidence of illicit drug use, and heroin use in particular.

(iii) Incidence and Prevalence of Multiple Substance Use

Most research on women drug users continues to focus on either alcohol or one type of illicit drug use (Wilsnack and Wilsnack, 1990). To date little attention has been paid to multiple substance use by women and we know very little about the antecedents, patterns of consumption (e.g. simultaneous, concurrent or alternating use) or consequences of multiple substance use for women in either the general community or the target population.

(iv) HIV Seropositivity and Risk Taking Behaviours

Surveys indicate a higher prevalence of injecting drug use among female prisoners (70%) (Miner and Gorta, 1986) than among the male prison population (36-42%) (Gaughwin et al., 1991b) or those detained in juvenile facilities (24%) (Zibert et al., 1994)[33]. A recent Victorian study found that 50% of women in prison reported sharing needles after learning about AIDS. The majority of women (68%) also reported using drugs in prison, with 41% indicating that they had shared needles in prison (Denton, 1994:47). This is higher that the 36% rate of needle sharing identified for the general prison population (Gaughwin et al., 1991a).

(v) Special Populations Research

Girls and Young Women

A recent report into juvenile justice in NSW found that girls were among the most distressed young offenders:

> "Of the six girls from one detention centre interviewed by the project, two girls had mutilated themselves, one had been cutting her arm; [an]other had smashed a window and cut herself for 'something to do' (Kids in Justice, 1990:314)."

Almost a decade ago, the NSW WIPTF also drew attention to the obvious need in relation to services which target teenage girls at risk of contact with the criminal justice system.

> "Mulawa contains many young women who could well have been identified as having drug problems in their early teens. There is a clear need for counselling and education programs designed to assist teenage girls, many of whom may not yet be willing to undertake long-term rehabilitation (1985:86)."

Ten years later, there is little evidence that the prison system is doing anything to meet the needs of young female offenders. As Mandy told me:

> "They've got a young offenders unit at Mulawa and there's nothing happening it - no programs, nothing. Like some of these young women are just straight out of Cobham, now is the time to really reach out to them and to try and get some positive things happening."

In the community, there are only two drug residential rehabilitation facilities in NSW which specifically identify adolescents or youth as their target client group -Dunsmore House in Sydney's West which operates a nine bed 14 day residential non-medicated detoxification unit and TRACA, a long term residential facility capable of accomodating 18 young people and run along NA lines by the Ted Noffs Foundation. In Victoria, Odyssey House operates a long stay residential program specifically for young people and in Western Australia, Palmerston and Holyoake both provide specialist residential services for adolescents. There is some evidence to suggest that there is a substantial overlap between the young people served by these programs and those identified by involvement with the criminal justice system (Noffs, 1994, personal communication).

A 1986 study which interviewed 100 'girls at risk' in NSW found that although most of these young women did not see their drug and alcohol use as a problem, of the 15 that did, only half had ever sought assistance. The most common barriers to treatment were identified as "being scared to seek help" and "concern about the stigma attached to going to a drug-related service" (Girls at Risk, 1986:195). More recent research suggests that as a group, young offenders have relatively little experience of treatment. Zibert et al. (1994) found that that three quarters of their sample of young offender detainees had never been in drug treatment. Of the 68 respondents with experiences of treatment, the majority (85.3%) reported receiving some form of counselling. Only 13 respondents (4.7% of the sample) had experienced residential drug treatment and of these, eight (61.5%) left prior to completion of the program. Reasons for leaving included "too many rules" and "too much confrontation" (Zibert et al., 1994:33).

Moreover, while 44 of the 279 detainees self-identified as having a past or current drug problem, only one third of these were actually receiving some form of alcohol or other drug treatment while incarcerated (1994:7,34).[34] According to these authors, existing services may be viewed as irrelevant by young people. Basing services for young people on adult treatment modalities may also be unsuitable given that adolescents are not typically as committed or immersed in drug using lifestyles and may be reluctant to seek help. In particular, evidence from a key informant involved in the provision of clinical services to young people suggests that an abstinence goal may be particularly inappropriate for this population. Research has also consistently found age to be a reliable predictor of retention in treatment, completion, decreased drug use and criminality, with patients who are under 25 significantly more likely to leave treatment prematurely (DeLeon et al., 1972; Sansone, 1980). Although few studies have examined women, recent research in Australia found that women less than 25 years of age were more likely to drop out of treatment (Copeland and Hall, 1992).

Finally, it is cause for concern that recent major reviews of adolescent drug treatment continue to ignore the needs of young women (Rahdert and Grabowski, 1988; see also De La Rosa and Adrados, 1993). In Australia, as elsewhere, there is a paucity of community based drug treatment interventions that specifically cater to young people and none that are available

for girls only. As Dimity, a young woman with extensive involvement in the juvenile justice system, told me of her experience in a mixed-sex residential program for adolescents.

> "It's just that its really hard sometimes caus' there's a lot of macho boys and they do a lot of really macho bullshit. They're bigger than you and they can stand over you. You feel intimidated by them and sometimes its hard to bring up resentments like how you're feeling caus' you think they're gonna smash you and stand over you and specially after a while when you've let down all of the fronts you had up while you're on the streets. Like you're genuinely scared and I used to get intimidated caus' they get really angry and violent and they act out on you ... like in group with abuse stuff and that, I couldn't talk about that, or what I'm scared of. Its really hard to be how you are caus' you feel like you have to be really big and strong. Like if you were scared of the dark they will all really laugh at you. The boys hide their fears much better."

However it is not only the attitudes of male program clients that may deter young women from seeking help with their drug problems. As Karen pointed out, pervasive gender stereotypes in relation to drug use also permeate the "helping professions", serving to reinforce the sense of social stigma and isolation that many young women feel:

> "We get associated more with the word whore and that. They're [boys] just junkies, we get junkie whore. Like when a boy comes home to a refuge drunk or out of it, the workers sort of say, you know, "mate, go to bed", but if a girl comes home like that its like, "well, what the fuck did you do that for?", you know, more condescending kinda thing, like you lost your virginity or something."

There is clearly a need for more research in relation to young women and girls involved with or at risk of contact with the criminal justice system. Although their numbers are small, young women currently constitute 7% of persons in juvenile detention facilities in Australia (Australian Institute of Criminology, 1994). While something is known about this population in NSW, there have been virtually no published reports of research conducted in other states. The recent introduction of a "Young Women's Programme" by the NSW Department of Juvenile Justice presents an opportunity for detailed study in the context of an evaluation of a specialist service and in particular, for assessing the effectiveness of drug and alcohol programs for young women in custody.

Aboriginal Women and Girls

Despite the fact that Aboriginal women have an imprisonment rate sixteen times greater than non-Aboriginal women (Hatty, 1984)[35], little is known about patterns of drug use among this population. The tragic drug-related deaths of four young Aboriginal women shortly after their release from custody in NSW referred to earlier underscore the urgent need for research which attempts to specify the nature and extent of drug use and related problems among Aboriginal women and girls involved with the criminal justice system[36]. Such research is a pre-requisite to the development of culturally sensitive treatment approaches which recognize the special needs of this population. In the United States, while sex and race are more typically associated with entry into treatment for illicit drug use (DesJarlais et al., 1983) studies of treatment outcomes which include sex and race interactions have tended to find less

favourable treatment outcomes among minority women (Savage and Simpson, 1980; Anglin et al., 1988). That Aboriginal women in Australia face substantial barriers to entering and remaining in treatment was confirmed by both the Aboriginal women interviewed in the course of this project. As Dimity told me of her experience in a mixed sex residential program for adolescents:

> "It caused heaps of hassles. Like you get heaps of kids come in with like these little white power tatoos on them, think they're hard core and that fuckin' shits me up the wall. I fuckin' hate that. You get heaps of racism. I get heaps of shit - "you're too white to be Aboriginal. I even get that from my own people - "Casper the ghost". I get heaps of it - "So, I spose you're an alcoholic" and I'm meant to be living in Redfern or Everleigh Street. I don't know, its just so fuckin' stereotyped ... I was the only Koori person in there."

NESB Women and Girls

Little is known about the incidence and prevalence of drug use among populations of NESB women in the general community. Recent research which indicates that such women rarely present to treatment in the community (e.g. Ribton-Turner and McDonald, 1992), suggests that there may be significant cultural barriers to NESB women seeking treatment. Research in relation to the use of D&A Services in NSW prisons found that NESB inmates were less likely to utilize these services (Kevin, 1993). An alarming trend recently identified in NSW concerns the more than 200% increase in Indo-Chinese juvenile detainees between 1991-94 (Department of Juvenile Justice, 1994a). As at 13 April 1993, seventy percent of Indo-Chinese youthful detainees had drug offences as their principle offence and young female Indo-Chinese offenders were exclusively involved in drug offences (Cain, 1994).

Research in the United States indicates that while women are more likely to perceive a need for treatment than men, in general ethnic minorities may be less likely to perceive a need for treatment and more likely to hold negative views in relation to treatment. This may be due to cultural beliefs against seeking professional help for what are regarded as personal problems (Longshore et al., 1993). However, focussing solely on cultural sensibilities precludes an examination of existing services, including the appropriateness of Anglo-American models of intervention for other ethnic groups and the ability or willingness of service providers to meet the needs of ethnic minorities (e.g. see Aguirre-Molina, 1991). As with Aboriginal women, there is a need for research which seeks to identify the patterns and correlates of drug use among NESB women more generally, as well as among those women and girls identified by their involvement with the criminal justice system.

Women with Dual Diagnoses

Women drug users are generally believed to have a higher incidence of attempted suicide and psychiatric contacts than their male counterparts (Reed, 1985; Oppenheimer, 1991). Drug dependent women are also more likely to have a dual diagnosis, with major depression being four times as prevalent in women than in men (Blume, 1990). Similarly, studies of incarcerated female populations also indicate a high prevalence of psychiatric disorders and illnesses (Scott et al., 1982; Turner and Tofler, 1986; Hurley and Dunne, 1991; Denton, 1993). However, little is known about the incidence of these problems among incarcerated populations of women drug users. Denton (1994) identified a total of 10 women (18%) in her sample of female prisoners in Victoria as either currently or previously suffering from a

dual diagnosis. While Denton (1994) found the incidence of self mutilation to be rare with only two women reporting this behavior (1994:36), she noted the specific problems women with dual diagnoses face in the prison context:

> "Women with a severe mental disorder and a substance depdendence disorder, along with women who are intellectually disabled, are among the most vulnerable and disadvantaged groups of women in prison. Women with a dual disability are received into the general prison where they fend for themselves. Here they face the taunts of other prisoners ...(1994:53)."

These women also have special needs in relation to drug treatment and in particular, in relation to withdrawal where, according to Denton, "psychiatric symptoms may manifest themselves ... [which] present difficulties for custodial staff who receive no training in the care and understanding of people who are in an acute psychotic episode" (1994:50). As Copeland et al have noted of this population in the general community, "It is tempting for drug and alcohol counsellors to interpret all their client's difficulties as symptoms of their substance misuse, and to offer simplistic solutions to chronic and complex problems" (1993:96). Clearly, there is a need for research which seeks to document the incidence and consequences of psychiatric co-morbidity among the target population.

IV RECOMMENDATIONS FOR CHANGE

4.0 Urinalysis Testing[37]

Given substantial expected differences between arrested, convicted and imprisoned populations (e.g. in the U.S., less than ten percent of all felony arrests lead to convictions resulting in incarceration), it is clearly imprudent to continue to base conclusions about the nature and/or extent of drug use among offender populations solely on imprisoned populations. It is recommended that an investigation be undertaken into the feasibility of instituting 'unmatched'/anonymous urinanalysis screening among arrestee populations, with a view to developing a more comprehensive data base in relation to drug use among offender populations.

Similarly, within the prison system, urinalysis is properly utilized as a research instrument and should be undertaken solely as a measure of drug use among the population and/or for purposes of program evaluation[38]. Urine testing in prison environment should be based on random samples[39] and administered by clinical staff in accordance with strict guidelines which take account of prisoner's needs for respect and dignity[40]. Testing should be unmatched so as to prevent the utilization of results as evidence against individual prisoners for the purposes of disciplinary action[41].

4.1 Screening and Assessment upon Reception to Gaol

Effective screening procedures are a pre-requisiste to any successful treatment intervention. Ideally such screening would occur in police custody. Failing this, reception into prison would appear to be the most appropriate point at which to establish such contact. Recent research conducted in NSW suggests that less than half the prison population currently

receives any form of drug and alcohol assessment (Kevin, 1993). It is recommended that all correctional institutions introduce specialist screening for alcohol and other drug problems on reception and develop a classification system for matching inmates to treatment interventions. As part of the general classification process, inmates should be assigned to a prison where the appropriate intervention is available. All inmates should be required to undergo some form of basic HIV education upon reception.

4.2 Detoxification

Each jurisdiction should review its criminal justice system processing practices to identify the point(s) at which detoxification needs are most acute and take steps to ensure that those needs are met at this point. This may entail the introduction or revision of laws and/or guidelines for detention in police custody to obviate the current situation whereby many drug users undergo lengthy unsupervised and unmedicated withdrawal while detained in police cells.

Screening upon reception to prison should seek to identify women undergoing withdrawal. Separately housed detoxification facilities with 24 hour medical supervision offering a range of medicated and non-medicated options should be available on demand. Steps should also be taken to ensure that the relevant protocols are made clear to all staff and complied with, particularly in relation to benzodiazepine and alcohol withdrawal.

4.3 Methadone

Consideration should be given to the introduction or expansion of prison-based programs in jurisdictions which have experienced signficant increases in the prison population. In addition to the studies already cited which attest to methadone treatment's efficacy in reducing drug use and crime, an increasing body of research suggests that methadone treatment may reduce the incidence and frequency of injecting drug use and needle sharing (Ball and Ross, 1991; Darke et al., 1990; Ward et al., 1992). A further body of research, reviewed in Hall et al (1993b:195-196), indicates that methadone treatment may serve to protect clients from HIV infection. There is also some evidence to suggest that prisoners in NSW perceive benefits attaching to the program in terms of decreased drug use while in prison and a reduction of drug-related violence in prison (Wale and Gorta, 1987).

Consistent with the philosophy of harm minimization which undergirds Australia's National Drug Strategy, those jurisdictions which do not currently offer methadone as part of prison-based drug treatment should investigate the possibility of initiating such programs. In particular, prisoners who are enrolled in community programs should be maintained throughout their imprisonment. Where this is not possible and inmates are withdrawn from methadone, withdrawal must be undertaken in accordance with established guidelines such as those outlined by Mattick and Hall (1993). Consideration should be given to removing barriers to participation in prison-based methadone program by increasing the number of "slots" available and expanding programs to include all institutions, including minimum security and works release facilities.

4.4 HIV/AIDS

Denton's (1994) finding that 68% of the women in her sample reported using drugs in prison and 41% indicated that they shared needles in prison suggest that AIDS education alone, while identified as a crucial element in treatment approaches designed to reduce drug-related harms, is either not effective in its current form or is simply not enough. The high level of needle sharing in prisons is particularly alarming in light of recent claims that bleaching does not kill the HIV virus. In line with Recommendation 9.5. of the Inter-Government Committee on AIDS Legal Working Party Report that "Governments should ensure that residents of correctional and other institutions ... have similar access to HIV/AIDS prevention measures as the rest of the community" (IGCA, 1992), it is recommended that consideration be given to the design and implementation of a scheme which provides prisoners with access (with immunity) to some form of needle exchange (possibly using disposable needles?).

4.5 Removing Barriers and Creating Incentives to Treatment

There exists a clear need to make drug treatment options more attractive not only to women prisoners but to all prisoners. Research in NSW and anecdotal evidence from other states suggests that existing drug treatment options are under-utilized. The reasons for this are currently unclear although factors such as the loss of income incurred through program attendance and the restriction of some programs to maximum security facilities have been suggested. Evidence from NSW suggests that the current criteria for inclusion in the prison methadone program may provide a powerful dis-incentive to prisoners insofar as prisoners are denied access to drug and alcohol counselling services provided by the DCS and participation in the program is currently confined to inmates resident in maximum and medium security prisons (Hall et al., 1993b). Such situations should be investigated with a view to creating incentives to treatment. In the absence of clear incentives, correctional authorities should ensure that active barriers in the form of dis-incentives which impede either access to, or participation in programs, are removed.

4.6 Program Goals

Where necessary, existing program goals should be (re)defined to include the reduction of criminal activity, HIV risk behaviours and other drug-related harms, as primary objectives of prison-based treatment interventions. Efforts should be made to minimize conflict between stated treatment goals and the contingencies of the prison environment. For example, while the NSW Department of Corrective Services has adopted a policy of harm minimization and committed itself to a recognition that "previous attempts to enforce a policy of abstinence for people with drug and alcohol problems have failed", the reality that "while they are in gaol abstinence is required" (NSW Department of Corrective Services, 1994) and indeed vigorously policed, serves to constrain treatment programming and compromises the integrity of interventions which identify harm minimization as a primary program goal.

4.7 Sexual and Physical Assault Issues

As outlined above, there is a clear need for research which seeks to document the physical and sexual assault histories of women in prison and the role of these factors in the etiology of women's drug use and related lawbreaking. There is also a need for consultation with the target population in order to identify their perceptions of treatment need. In the absence of such research, the efficacy of program components which focus on sexual and physical assault issues remains unclear. Given the dangers of addressing such issues in a group setting in the prison environment, extreme caution should be taken in relation to group therapy approaches. In light of the above, it is recommended that specialist individual therapeutic interventions be available on request, paying particular attention to the need for confidentiality in the prison setting.

4.8 Relapse Prevention

A major component of treatment programming is relapse prevention techniques which assist clients in monitoring and managing high risk situations. Recent research indicates that the determinants of relapse and recent substance abuse among offender populations may be gender differentiated. Unresolved issues in relation to sexual abuse are widely believed to pose risk factors for relapse in women (e.g. Rohsenow et al., 1988; Young, 1990). Research also suggests that in comparison to male offenders who were more likely to report determinants of recent susbtance abuse as related to positive emotional states, women offenders are more likely to identify intrapersonal determinants related to negative emotional states (including depression, boredom, anxiety and tension), substance use in the presence of a boyfriend or drug dealer, in response to seeing drug/alcohol paraphenalia and in the presence of friends known to use drugs (Peters and Schonfeld, 1993).

These findings suggest that interventions specifically tailored to female inmates need to focus on identifying negative emotions that lead to relapse and the development of appropriate strategies for their management. In addition, as the authors suggest, they may also "reflect the need for female offenders to develop autonomy in heterosexual relationships, and to break the cycle of financial and emotional dependency that often characterizes their relationships with drug dealers or drug-using boyfriends" (1993:114). In place of generic relapse prevention components, it is recommended that efforts be made to identify and address the specific determinants of relapse among populations of female offenders.

4.9 Specialist Women's Service Approach

For many women, and women in prison in particular, drug problems are often symptomatic of much deeper social and economic problems. These symptoms, and therefore the interventions required to mitigate them, extend beyond the physical and psychological to include what are often profound social, legal and economic problems. Accordingly, drug treatment cannot be simply conceived of in terms of a medical model of acute illness and effective approaches to what are construed as "drug problems" must begin to incorporate meaningful life options and choices for those women who currently have little incentive to "just say no". By definition this involves simultaneously addressing the inter-relationships

between drug use and other problems in women's lives such as poverty, unemployment, discrimination, sexual abuse and physical violence (e.g. see Reed, 1991). Many women simply cannot afford to put these other problems on the "back burner" in order to deal exclusively with their drug(s) problems.

There is little to indicate that the profile of 'drug-dependent' women in prison developed by the NSW WIPTF has changed -i.e. the majority are "young, working class and caught up in a cycle of poverty, unemployment and homelessness" (1985:82). Research also suggests that large numbers of women in prison are likely to have histories of sexual and physical abuse and most are mothers with pressing concerns in relation to the care and custody of dependent children (WIPTF, 1985). In summary, existing evidence suggests that women in prison constitute a population characterized by a high incidence of women previously identified as having needs which are unmet by existing models of service delivery (Copeland et al., 1993). Treatment interventions which seek to target this population must therefore contend with the range of factors which undergird, condition and sustain their drug use in order to effect meaningful long-term change.

While not mutually exclusive of the recommendations outlined thus far, a pilot program to establish a comprehensive prison-based residential unit for female drug users should be initiated. This program should be based on the philosophy of a specialist women's service utilizing primary program goals of harm minimization within a client-centred non-confrontational therapeutic approach concerned with empowerment and skills-based treatment. Confrontational therapies such as "criminal lifestyle confrontation" are clearly inappropriate for women. The following components are suggested for inclusion as core modules:

- identification, orientation, assessment and treatment planning
- cognitive skills training
- interpersonal relations and communication skills
- health and wellness concerns
- legal, housing and welfare issues
- children and parenting concerns
- education and work skills
- non-confrontational group and individual counselling (including specialist individual sexual and physical assault and domestic violence counselling provided by female therapists)
- recreation
- relapse prevention
- pre-release and transitional issues
- institutional after-care and post-release services

4.10 A Continuum of Treatment Options

Consistent with the approach outlined in Recommendation 4.9, a continuum of supported treatment options, balanced between institutional and community based interventions, should be available for female drug using offenders. More attention needs to be placed on developing "front end" strategies for the diversion of female drug users into community treatment programs which are sensitive to their needs.

In NSW, a Drug and Alcohol Court Assessment Program (DACAP) has been in operation since 1979. This program, designed to facilitate the diversion of drug and alcohol involved offenders from custody into treatment programs, is currently administered by the Community Corrections Service. However, pre-sentence reports prepared under the program constitute only 4% of all such reports and there is some evidence to suggest that the service is not as effective as it could be. While the reasons for this have been outlined elsewhere (MSJ Keys Young, 1992), the high incidence of both drug use and primary childcare responsibilities among populations of female offenders, indicate an urgent need for the development of a gender-sensitive inter-agency approach to diversionary programs for drug and alcohol involved women.

Within the context of incarceration and the specialist therapeutic approach outlined above, women should be given meaningful work at realistic wages that permits them to meet their needs in prison and save funds in preparation for release. Concerted efforts should also be made to improve staff training and professionalism with a view to increasing the quality of staff-prisoner interactions and enhancing the prison environment. Attractive recreational options should also be provided for women in prison. Women who receive effective preparation for release through the provision of intensive pre-release program components, including work release (see above), should be confident upon their release that they will receive continuity of services, as well as supervision. Further reference should be made to the Report of the NSW WIPTF (1985).

4.11 Greater Consultation with Target Population

Consultation should be conducted with the general target population, as well as with each of the specific sub-groups in relation to what they believe to be their treatment needs and specifically, in relation to sexual abuse and domestic violence issues. While there exists an urgent need to identify the treatment needs of women prisoners as a group, such research should not ignore the needs of sub-groups within the population and in particular, the needs of girls and young women, Aboriginal women and girls, NESB women and girls and women and girls with psychiatric problems.

4.12 Broaden Research Data Base

The key informant interviews conducted for this project indicate a need for studies which utilize prison-based samples to be offset by research among non-captive populations of women and girls at risk of contact with the criminal justice system and women and girls recently released from custody. There is also an urgent need for research which follows women and girls upon their release from custody in order to assess reports of a high incidence of drug-related mortality. Such research should not be carried out purely on an in-house on commercial consultancy basis. As has been recommended elsewhere, while there is a need for greater collaboration between criminal justice agencies and external researchers (e.g. MSJ Keys Young, 1992), it is clearly desirable that collaboration be carried out with researchers who have specialist expertise, such as that provided by universities and affiliated centres.

4.13 Cost Effectiveness

Finally, there is a paucity of research in relation to the cost-effectiveness of drug treatment in relation to offender populations, particularly as concerns the potential of treatment interventions for reducing the costs associated with drug-related criminality. Although some research has been carried out in the United States (Hubbard et al., 1989) with promising results, there is an urgent need for similar research in the Australian context. Given that drug users are among the highest rate offenders in the criminal justice system, interventions which result in positive treatment outcomes with this group are more likely to produce results that are cost effective in both economic and social terms, than measures which are successful for more cooperative clients with lower base expectancies for crime and drug abuse.

Notes

1. This paper does not seek to address drug use by the large population of offenders who remain unknown to the criminal justice system.

2. While studies of arrestee populations have historically utilized self-reports of drug use, research in the United States is increasingly based on urinalysis, either alone or in combination with other indicators. The use of urinalysis test results as a data source has a number of advantages over self-reports insofar as many arrestees do not report their drug use during criminal justice system processing. One study found that less than half of arrestees who tested positive for drugs reported recent drug use in confidential research interviews (Wish and Gropper, 1990), suggesting that accurate self-reports of drug use to criminal justice system personnel may be even less likely.

3. The over-representation of drug users among female arrestees may however, reflect the sex-segmented labour market structure of the informal or criminal economy insofar as women drug users are more likely to engage in prostitution as a means of supporting their drug consumption and are therefore more visible and vulnerable to arrest than male users (Maher and Curtis, 1992; Maher, forthcoming). In the local context it has recently been suggested that vigorous [over]policing in the Kings Cross area of young women soliciting for prostitution forms at least part of the background of young female drug users in detention centres in NSW (Bargen, 1993).

4. While this is consistent with the findings of American research which suggests that women prisoners are more likely to have used illicit drugs than men (e.g. Bureau of Justice Statistics, 1991), some evidence also suggests that alcohol may play a significant role in certain types of offences. A recent review of studies of women convicted of homicide in the United States suggests that between one-quarter and two thirds of women were primarily abusers of alcohol and between one third and one half of the victims of these homicides were using alcohol at the time of the offence (Silverman et al., 1991).

5. It is important to note that most of these studies only sample women relevant to their representation in the population. To date few Australian studies have either focussed exclusively on women or sought to oversample them.

6. The Co-ordinator of Alcohol and other Drugs in the NSW Department of Juvenile Justice claims that these deaths contributed to later changes within the Department, including the relocation of the young women to a specialist facility, the institution of a 'Young Women's Program' and the adoption of a 'therapeutic model' (Barton, 1994).

7 . Unfortunately much research tends to define involvement in crime rather liberally with many studies using what are arguably 'delinquent' but not seriously criminal acts as an index of pre-addiction criminality. This is clearly inappropriate given findings from the National Youth Survey which indicate that while the prevalence of opioid use among American youth (15-21) in the general population is less than 1%, at least 18% reported having engaged in theft of some kind (Elliot et al., 1983).

8. This research should not be taken to assume that most addicts are criminally deviant, due to the over-representation of known offenders, and the paucity of research on those who commit criminal acts but who are not brought to the attention of the justice system.

9. Somewhat paradoxically, women's under-achievement in the arena of offending has brought them little benefit within the prison system. Women's status as a statistical minority (5-6%) among imprisoned populations has produced severe discrimination in relation to the provision of facilities, opportunities and programs. As Carlen (1983) has argued, the reasons for the denial of women's imprisonment can be found in the belief that women are neither sufficiently "dangerous" to be feared nor statistically important enough to warrant attention. Despite the fact that imprisoned women have unique needs and responsibilities and evidence different behaviour from imprisoned men, within the Australian context, there are currently no separate intake and classification procedures and few prison-based programs specifically designed to meet women's needs.

10. It is important to note that there is often a considerable dysjuncture between treatment goals held by users and those identified by service providers. For example, a recent study of homeless women heavily immersed in street-level heroin and crack cocaine consumption in New York City found that women utilized inpatient detoxification facilities on a periodic basis as a form of respite care. This kind of indigenous harm minimization strategy can be viewed as a legitimate and rational attempt to reduce the costs associated with drug use and associated high risk lifestyles in the context of extreme poverty, homelessness, excessive levels of violent victimization, poor general and reproductive health, and high rates of HIV seropositivity (Maher, forthcoming).

11. In the U.S. research is currently underway which seeks to test the efficacy of three techniques (case management, personal referral and use of videos tapes) for reducing drug use and AIDS-risk behaviours among arrestee populations (Gross and Rhodes, 1993).

12. By contrast, unsuccessful programs are often based on a "disease" model which views both crime and drug use as sicknesses and the appropriate response as a medical one. Similarly, intervention programs based on specific deterrence principles (e.g. "Scared Straight") have shown very limited effects and in some instances, have been associated with increased offending.

13. Given evidence which suggests that prison-based drug treatment may assist in reducing the level of tension, rule infractions, violence and threats of violence in the prison environment (Wexler et al., 1988), such interventions may also be considered as an investment in the overall security, manageability and good order of the institution (Frohlin, 1989).

14. Despite increases in the actual population, this proportion has tended to remain stable over time. The number of women in prison increased from 554 in 1986 to 760 in 1992 while the number of imprisoned males increased from 10,943 to 14,799 (Walker and Biles, 1987; Walker, 1993).

15. In 1976 Rowena Newell choked on her own vomit while withdrawing from heroin alone in her cell (Bacon, 1983).

16. This was despite the efforts of the WIPTF Implementation Committee and the Director of the [since disbanded] Women's Services Division within the DCS (Judy Johnston) in authorizing the allocation of funds for the refurbishment of Morgan House to provide a detoxification and drug treatment facility at Mulawa. Although Morgan House was upgraded, it was subsequently used as separate accomodation for prisoners who worked in the gaol kitchen.

17. A recent survey of NSW prisoners found 17% reported weekly benzodiazapine use during the year prior to imprisonment (Stathis et al., 1991).

18. This study classified 29% of women a having a pre-arrest substance dependence on benzodiazepines (Denton, 1994).

19. For example it has been reported that at one time the entire HIV/AIDs (peer education) support group at Mulawa was placed in segregation, ostensibly for the "good order and conduct" of the prison (Anonymous, Mulawa, 1991; cited in Hampton, 1993:34).

20. The five successful randomised controlled trials of methadone which have been conducted to date are reviewed in Mattick and Hall (1993), as are a selection of quasi-experimental studies.

21. Although both Victoria and South Australia provide for limited availability to some prisoners, neither program is strictly a "maintenance" program. The Key Extended Entry Program (KEEP) which has been run out of New York City's Riker's Island since 1987 by Montefiore Hospital's Riker's Health Service is believed to be the only other prison-based methadone maintenance program (Magura et al., 1993). However, this program excludes pre-trial detainees charged with anything other than misdemeanor offences and inmates serving sentences in excess of one year. In effect, the great bulk of the city's prison population, including a large number of those offenders with high base expectancies of crime and drug use post-release, are denied access to this program.

22. As Hall et al. have pointed out, major shifts in the rationale and goals of this program have hindered efforts at evaluation (1993:197).

23. While according to Hall et al. (1993b) this may also be at least partially due to an abstinence orientation on the part of many counsellors, Hampton (1993) has argued that it is due to the assumption that once on methadone, "their [drug] problem is under control" (1993:111).

24. This estimate is based on the population of 6392 derived from the 1993 NSW Prison Census (Eyland, 1993).

25. For example, Mattick and Hall recommends that methadone withdrawal proceed by way of reduction of the dose "at a rate no greater than ten percent of the current dose each week, based on the previous week's level" (1993:xiii). This report also cautions that methadone programs do not terminate at the cessation of doseage and strongly recommends the provision of aftercare services (Mattick and Hall, 1993:xiii).

26. The highly restrictive policy on prisoner property introduced in 1990 by the then Minister for Corrective Services (Michael Yabsley) prompted major disturbances thoughout NSW prisons. Women responded to the implementation of this policy (which included the confiscation of cell furnishings, personal effects, books, letters, children's drawings and jewellry and the restriction on clothing to minimal amounts - e.g. two tracksuits, three T-shirts, five pairs of underwear, two bras and a ban on hats) by smashing prison property and setting fires and were subsequently locked in their cells for eight days.

27. Research conducted by the Australian Institute of Criminology found that overall, prisoners were five times more likely to commit suicide and three times more likely to be victims of homicide than the general population (Hatty and Walker, 1986:29-31).

28. In 1993-94, there were 29 confirmed deaths in NSW prisons attributed to drug-related causes, suicide or murder, representing a 40% increase over the previous year's figures (Sydney Morning Herald, 25 July, 1994).

29. While the response to self harm now takes the form of sedation and/or isolation, until recently self-mutilation or attempted suicide was dealt with as a breach of prison discipline. In NSW women charged with the offense of 'inflict wound on self' were brought before the Visiting Justice. The WIPTF (1985) found that while self mutilation accounted for more than one quarter of all disciplinary matters concerning women brought before the Visiting Justice, the number of similar charges against male prisoners was insignificant. While women are no longer formally charged, in practice self harm constitutes a "black mark" on a prisoner's file which, among other things, may impede transfer to a minimum security institution.

30. An additional seven women (13%) were identified as having a current "mood disorder" and four women (7%) were defined as having a "psyhotic disorder" (Denton, 1994:20).

31. It is also the case in many jurisdictions that there are not enough jobs in women's prisons for those who want - or need - to work.

32. In NSW the issue of assessment is further confounded by the fact that such 'assessments' as currently exist may be undertaken by either CHS or DCS staff. Despite this apparent duplication, these services clearly still do not reach the target population (see Kevin, 1993).

33. Estimates obtained from studies of new receptions to prison are considerably lower, indicating that between 18 and 23% of males are injecting drug users (Stathis et al., 1991).

34. As Zibert and his colleagues concluded, "Either detainees who desire drug treatment are not being identified as needing such treatment or the services offered are not meeting the needs of detainees" (1994:52).

35. Currently, Aboriginal and Torres Straight Islander women represent 13.1% of the female prison population in NSW as compared to Aboriginal and Torres Straight Islander males who comprise 10.6% of the male prison population (Eyland, 1993).

36. Persons of Aboriginal background are even more grossly over-represented among juvenile detainees. While Aboriginal youth constitute only 1.8% of the NSW youth population, they currently represent almost one quarter (24.8%) of young people in custody in NSW (Cain, 1994). Although there are considerable variations at the state level, nationally, Aboriginal and Torres Straight Islander young people are at least 19 times more likely to be in juvenile detention than non-Aboriginal and Torres Straight Islander youth (Australian Institute of Criminology, 1994).

37. Of course the reliability or urine testing as a measure of drug use will be affected by factors such as the number and type of drugs screened for, the type and amount of drugs consumed, duration between actual use and provision of the specimen, individual metabolic rates and the incidence and effectiveness of practices such as 'flushing' - the consumption of large amount of fluids in anticipation of testing.

38. While there are sound arguments for matched testing as an adjunct to treatment programming (e.g. methadone recipients), within the prison context it is arguable that the problems of ensuring confidentiality outweigh the possible clinical benefits.

39. For example, Hampton (1993) claims that in NSW, the same non drug using women were sampled repeatedly as part of a "cosmetic activity which allows Corrective Services to delude themselves that they are 'doing something' about prison drug trafficking" (1993:110).

40. The collection of urine samples is usually undertaken by custodial staff. In Victoria, women are currently strip searched, undressed and forced to urinate in the presence of a prison officer (George, 1993:32). At present no states require that an officer supervising the collection of urines be of the same gender as the prisoner.

41. Evidence from key informants suggests that for women prisoners, being unable or unwilling to supply urine specimens may result in even more severe punishments than those which result from testing positive for the presence of drugs, including segregation, denial of contact visits and loss of income (see also George, 1993).

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MODELS OF ALCOHOL AND OTHER DRUGS SERVICE DELIVERY AMONG WOMEN

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EXECUTIVE SUMMARY

This paper will discuss the key elements alcohol and drug treatment services need to provide in order to be effective options for women. It will argue that no discussion on matching client and treatment is complete if the specific needs of women are not included. Furthermore, it proposes that specialist women's drug and alcohol services, having a specific target group, are in a better position to be the effective match for women, than services with a diverse client group.

I POLICY AND RESEARCH

Currently the consensus in Australian policy and research on drug and alcohol treatments is that the matching of individuals to methods of treatment could be the most effective way of improving outcomes (Heather and Tebbutt, 1989; Miller and Hester, 1989; Ali, Miller and Cormack, 1992; Ali and Cormack, 1994; Jurd, 1994). The NCADA Monograph No. 11 reviews the scientific evidence of effectiveness of treatment covering: aspects of treatment; treatment approaches; setting and duration of treatment (Heather and Tebbutt, 1989).

This monograph appears to be a comprehensive overview of alcohol and drug treatments, except that women are not mentioned. Heather and Tebbutt raise the importance of assessment, stating: "It is believed that accurate matching of individuals to optimal treatment methods and goals could result in an overall improvement in success rates." (ibid) In order to ascertain if there is evidence to support this belief, more research into client characteristics as predictors of appropriate treatment approaches for optimal outcomes, needs to be done. To ensure this research is relevant to women, gender must be considered as a characteristic likely to impact on treatment effectiveness. A recent paper, summarising recommendations of the Australian Quality Assurance Project on interventions for alcohol problems, indicates that research is beginning to acknowledge gender as a variable. Women are not specifically considered in the recommendations for each of the interventions, however the authors note:

> "Although the treatment outcomes for men and women are very similar, research suggests that men and women have different needs during alcohol treatment. There is evidence that women suffer social disapproval and other hardships related to treatment entry. Services such as all-female treatment programs, child-care facilities and sexual abuse trauma counselling may play an important role in improving the quality of treatment for women." (Mattick and Jarvis, 1994)

This is a start, but in order to develop a comprehensive knowledge base that can inform policy and practice on the most effective treatment approaches for women, gender needs to be a feature in the design of all research. Findings of studies with all or predominantly male subjects cannot be assumed to apply equally to women. If women are not present in a population, or are present but too small in number for conclusions to be drawn, or their results differ from the major findings of a study, then this must be stated.

II TREATMENT APPROACHES SUPPORTED BY THE LITERATURE - DO THEY APPLY TO WOMEN?

An intervention currently favoured by policy writers and seemingly supported by research, is early or minimal interventions delivered by general health workers, in particular, medical practitioners. Heather and Tebbutt (1989) cite a number of studies that conclude early interventions can be effective in reducing excessive use of alcohol and tobacco. The results in all but one of these studies, as reported by Heather and Tebbutt, fail to mention women. Early interventions may prove effective, but before it is assumed that this will be equally the case for both men and women, more questions need to be asked. Women are more likely to present to health services, particularly general practitioners (Copeland, et al, 1993). They are

in the right place for early intervention, however, the practitioner's perceptions of, and beliefs about, women often leads instead to the prescribing of medication for problems related to social issues (Burnett, 1994). Medical practitioners may not be the most appropriate health professionals to offer this type of intervention to women, given that they prescribe tranquillisers twice as often for women as for men (Lennane, 1987; Mant, 1989; Moore, 1992). This approach is likely to give conflicting messages to women - raising awareness about the harm related to one substance whilst being the source of another. Another consideration should be the content of the intervention. Are different aspects of early interventions more effective for women? Information and advice re the drug use may be a significant factor for men, whilst being listened to or given advice on alternative ways of dealing with stressors could be more significant to women. Exploration of these questions would ensure early interventions are employed to maximum effectiveness as men and women could be targeted with the most appropriate setting and approach.

Another discussion currently to be found in the literature on treatment approaches is "inpatient versus outpatient". A number of writers have concluded, after reviewing various studies, that there doesn't appear to be any superiority of outcomes for those people receiving inpatient treatment (Heather and Tebbutt, 1989; Hester and Miller, 1989; Saunders, 1989; Ali and Cormack, 1994). From a cost-effective perspective, Heather and Tebbutt (1989) argue that outpatient treatment is the preferred approach, except in the case of illicit substances when compared with the cost of imprisonment. Ali and Cormack (1994) favour outpatient settings as the way to impact on the most people for the least cost:

> "...low intensity interventions...are as effective for low dependence drinkers as more intensive interventions, they cost little in terms of resources or time to deliver and, hence, it is theoretically possible for large numbers to be delivered cost-effectively to the large numbers of low dependence drinkers."

It should be noted that the subjects of the studies cited in these works are overwhelmingly male. Furthermore, in each publication cited above, there is acknowledgment that for some people a residential setting is a factor which enables them to benefit from drug and alcohol treatment. For instance, Saunders (1989) notes:

> "In-patient treatment may be necessary for detoxification, for treatment of co-existing medical or psychiatric disorders or to provide 'time out' from a tense domestic situation."

Many of the particular difficulties women experience when they seek drug and alcohol treatment would indicate a residential setting is often the preferred approach. It has been found that women who have problems with drug and alcohol use report high levels of sexual and physical abuse, including incest and domestic violence (Thom, 1987; Rohsenow, Corbett and Devine, 1988; Connexions, 1989). This background is often combined with little or no support from family or friends to undertake drug and alcohol treatment. One study of men and women, which looked at problems on entry into treatment, found:

> "Women were more likely to have had recent experience of violence from their partners and to have received less support for entry into treatment." (Thom, 1987)

Women are also more likely to have a partner who is drug dependent and to have been introduced to alcohol or drugs by a partner (Reed, 1985; Zankowski,1987). In a recent article supporting inpatient treatment for some, Stephen Jurd writes:

> "It would be ludicrous to send an individual back to the homeless men's shelter or his hotel room with a packet of pills and instructions to abstain." (Jurd, 1994)

By the same token, it is equally useless to send a woman back to an unsupported or abusive domestic situation and expect an outpatient intervention to have made a difference. To remain within a person's usual environment whilst undertaking treatment is often advocated (Heather and Tebbutt, 1989). This, however, assumes a level of support from family and friends that is non-existent for women who are: in violent or abusive relationships; socially isolated; and/or reluctant to ask for support because of low self-esteem or fear of the stigma attached to women with drug and alcohol problems (Copeland, et al.,1993).

Miller (1989) found that there are times when inpatient settings are indicated:

> "...there is evidence that more intensive treatment approaches are differentially effective for persons who have severe levels of alcohol problems and dependence, or who are socially unstable (homeless, unemployed, indigent)."

It can be argued that women who require drug and alcohol treatment experience severe levels of substance use problems. For instance, in addition to drug and alcohol dependence, women are more likely to have a history of depression, attempted suicide, eating disorders, and poly drug use (Copeland, et al, 1993). It has also been suggested that, because of gender differences in body weight and amount of adipose tissue women reach higher blood alcohol levels, making them more susceptible to the physical effects of alcohol, including liver cirrhosis, breast cancer, pancreatitis and brain damage (Corti, 1988). Women's reproductive health needs, particularly pregnancy, require specialist treatment options that will ensure the physical safety of women and children.

Ali and Cormack (1994) argue that the inpatient component of drug and alcohol treatment does not, in itself, improve the outcome of that treatment. They suggest that, either the concurrent treatment of co-existing physical or social problems has made the difference, or, in the case of homeless people, it is the supported accommodation, rather than treatment, which has had the major impact. They conclude that funding, other than alcohol and drug treatment monies, should be used to provide these other aspects of care. However, it should be noted that Ali and Cormack also point out that: "The key factors which make any treatment effective are as yet to be identified." To ensure effective matching of people to treatment more research that differentiates between outcomes for treatment modality and treatment setting is needed. This is particularly true for women given the scarcity of research that has specifically measured the effectiveness of outcomes for women in **any** treatment setting.

III WOMEN AS THE PRIMARY CARERS OF CHILDREN

A factor that is rarely, if ever, taken into account when assessing effectiveness of treatment is parenting. As women are generally the primary carers of children this is an area particularly pertinent to any discussion on treatment options. Many studies cite lack of child care as a barrier to women entering drug and alcohol treatment (Reed, 1987; Birrell and Jarvis, 1988; Waldby, 1988; Begg and Rossel, 1991). Women often state that concern for their children leads them to seek treatment, however they are hesitant to use drug and alcohol services for fear of losing their children. Providing child care is one step towards allaying a woman's fears, in that she can have her children accompany her - whether that be in an outpatient or residential setting. In a comparative study of a specialist women's service (which provides child care) and two mixed-sex services, the authors of *Evaluation of a Specialist Drug and Alcohol Treatment Service for Women: Jarrah House*, found that:

> "...women with dependent children who completed treatment were more likely to have attended Jarrah House than the Comparison Services."

and

> "...significantly more women with dependent children prematurely discharged themselves from traditional mixed-sex services, where their child-care needs and parenting concerns were not being met." (Copeland, et al., 1993).

To be an effective option for women with dependent children, the setting and type of drug and alcohol treatment needs to incorporate ways of addressing, not only care for the children, but also parenting concerns. Failure to do so can result in a less effective treatment outcome for the mother, and impact negatively on her children. Copeland, et al., point out that:

> "... the legacy of dysfunctional child-rearing patterns for the child may be malnutrition, developmental delays, learning disorders and future substance abuse."

Therefore, it is not only in the interests of women that drug and alcohol services are accessible to women with dependent children, but also important for the sake of the children.

Traditionally, drug and alcohol services, by and large set up to meet the needs of individuals, have not catered for parents. If concern for her children is a factor in a woman seeking treatment for her drug and alcohol use, then the treatment approach which can address her needs in this area is more likely to have a better outcome.

> "The magnification of existing feelings of guilt, shame and failure surrounding their maternal role, if left unaddressed, may negatively effect treatment outcome as women use alcohol and other drugs to cope with these intense emotions after discharge." (ibid)

A residential setting is often the most effective in which to address parenting issues. Children can safely accompany their mother, enabling identification of difficulties and supported opportunities to try out alternative ways of parenting. Although substance use is not necessarily indicative of child abuse and neglect, there are often associated problems that can

negatively effect the parent-child relationship. These can include: the mother having experienced abuse or inadequate parenting as a child; lack of support networks; feelings of low self-esteem and/or depression; poor physical health; and financial difficulties (Reed, et al, 1982). Faced with such issues, it is not surprising if a woman has difficulty finding the energy necessary for consistent parenting. Hence, there are times in the process of drug and alcohol treatment, when both mother and child require care and nurturing whilst they establish or re-establish a relationship in which the child receives adequate parenting. Failure to do this may exacerbate any parenting problems:

> "...abusive behaviour toward children may even increase while a parent copes with withdrawal and learns to live without drugs as a buffer for feelings." (ibid)

IV BUT, A WOMEN'S SERVICE IS MORE...

Providing child care, support with parenting and a safe, women-only space (where women can explore their drug and alcohol use away from abusive relationships), only goes part of the way to ensuring an appropriate treatment match for women. The evaluation of Jarrah House found that six months after treatment there were no significant differences in outcomes between the women who attended Jarrah and those from mixed-sex services. It should be noted, however, that the women who chose and remained in the program at Jarrah House had the more serious and complex problems. Even so, the authors concluded that the lack of differences in outcomes was, at least in part, attributable to the fact that the theoretical basis of both the women's and mixed-sex services were similar - disease model and twelve-step programs (Copeland, et al, 1993).

Much of the literature which looks at women in drug and alcohol treatment identifies a dependence on men that has often been instrumental in establishing and continuing a woman's dependence on drugs and alcohol (Zankowski, 1987; Wedenoja and Reed, 1982). A treatment approach which relies upon acceptance of the idea that an individual has no power over a drug (as the disease model does), and that in order to change, the individual must shift their dependency from the drug to a "higher power" (the basis of twelve-step programs), can perpetuate a state of dependency for women. An approach that enables women to set their own goals and make their own decisions regarding the process of treatment will assist in challenging this notion of dependency. There is no one treatment model that is effective for all individuals (Miller and Hester, 1989), therefore a range of approaches should be offered to women. This range must include treatment approaches that have been developed by listening to women, rather than adopting male-centred theories, and are able to specifically meet the needs of women. For example, approaches that: recognise the positions and perceptions of women in society and can offer women new possibilities by challenging these; assists women in their mothering role; can safely support women who have been abused.

The flexibility of approach must also recognise goals in treatment other than, but not excluding, abstinence. Women who present to services do not always see drug and alcohol use as the problem on which to focus (Thom, 1987; Reed, 1987). Often, their concerns will be with their children, their mothering role, relationships, or other issues such as childhood abuse. As mentioned above in relation to parenting, failure to acknowledge and address the priorities of women is likely to have a negative impact on treatment outcomes.

For women to fully benefit from treatment it is often necessary for it to be offered in a women-only setting. In mixed-sex groups, women are not always allowed the opportunity to try out different ways of being, but slip, or are forced into, familiar patterns of relating to men and other women.

> "...drug and alcohol dependent women slip easily into pleasing roles, patterns of manipulation, acceding to male authority and exhibiting hostility towards other women in a mixed-sex group." (Copeland, et al, 1993)

There is also an issue of safety in mixed-sex groups. Women have reported feelings of vulnerability and incidences of sexual harassment within mixed-sex programs that have lead them to leave the service prematurely (Begg and Rossel, 1991). Copeland, et al, (1993) also found that women with a history of sexual abuse were more likely to present and remain in the specialist women's service. Given that treatment approaches in that service were similar to those offered in the comparison mixed-sex services, it may be concluded that the women-only aspect was a significant factor. The study also found that the women's service was more likely to attract and retain lesbian women in treatment, again it can be assumed that a reason for this was the women-only setting.

It should also be noted that for a woman to maintain changes made, in relation to her drug and alcohol use, she may need supports over a period of time. Many of the issues women face (for example, parenting difficulties; past or current history of abuse) require long term counselling, self-help groups, and/or specialist services such as child and family services. It is therefore important that women's drug and alcohol services are integrated in health and welfare service systems that can assist women with ongoing support.

V PROVIDING EFFECTIVE TREATMENT APPROACHES FOR WOMEN

The theoretical knowledge that is needed in order to develop treatment approaches that are effective for women is available. There is, however, a lack of empirical research to support this knowledge (Copeland, et al, 1993). This gap in research has occurred largely because few specialist women's services have existed, and their poor survival rate has meant limited opportunity to undertake extensive research. This lack of empirical data should not be construed as an indication that specific treatment approaches for women are not effective. As Heather and Mattick point out:

> "... the reason some of the commonly used methods ... lacked research support is not necessarily because they are ineffective treatments but because they have never, or hardly ever, been evaluated. When these methods are subjected to competent scientific scrutiny, they too may gain empirical evidence of effectiveness." (Heather and Mattick, 1994)

In conclusion, what the lack of research means is that there is little evidence available to legitimate policy and practice advocating the development of specialist women's services. Hence, the decisions regarding the funding of services for women, will continue to be based on "...economic considerations rather than empirical knowledge." (Ali, et al, 1992)

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WOMEN AND DRUG USE: IMPLICATIONS FOR THE EDUCATION AND TRAINING OF GENERALIST WORKERS

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EXECUTIVE SUMMARY

Since the mid-1980s successive alcohol and other drug (AOD) plans have implied that for reductions in drug-related harm in the community to be achieved, the majority of workforces outside and inside health needed to become more effectively involved with AOD problems. In the AOD area such workforces are referred to as generalist and are seen as having a vital role to play in early intervention and health promotion or prevention.

The primary health care workforces and community services workforces have been identified as priority generalist workforces. In both of these women are the majority of workers. A strategic opportunity for women's AOD issues to be dealt with by women, has therefore been created. Power imbalances are in part, however, preventing this opportunity from being realised. An analysis of AOD plans and research indicates that womens' place is being marginalised in both the AOD plans and the research.

Despite the general lack of research available on women's AOD issues in education and training an attempt is made to explore how the different workforces fare in dealing with women's AOD issues. Emerging research on women's AOD issues and interviews with key informants are used to explore doctors, nurses, and community services workers responses to women's AOD issues.

A conclusion is reached that despite some promising signs women's AOD issues are still not comprehensively integrated in the education and training of primary health and community services workforces. A way forward may be found in the model of gender inclusive curriculum being developed in the vocational sector. Using this model and what we have learned about women's AOD issues it is possible to develop at least the beginning hallmarks of a gender- inclusive generic AOD curriculum model for health and community services workers.

This paper will have achieved its purpose if it prompts discussion and debate on these issues which lead to the further integration of women's AOD issues in the education and training of the health and community service workers.

Terms: See Appendix for definitions and usage of terms such as "Other Drug", "harmful" use, "hazardous" use and "informants".

Approach: See Appendix for a brief discussion of how that data for this issues paper was gathered.

I INTRODUCTION

Recent National and State AOD plans set clear outcomes to reduce the toll and cost of harm caused by the consumption of alcohol and other drugs. The same AOD plans since the mid-1980s have also implied that for their outcomes to be achieved workforces outside and inside health need to become more effectively involved with AOD problems. In the AOD field, these workforces are referred to as "generalist" and include health workers, teachers, police, welfare workers and workplace managers. These may be loosely described as workforces where the worker has contact with clients who have an AOD problem or issue. However, treating and working with substance problems is not their main or only role. While earlier definitions of the generalist's role with AOD clients focussed on assessment and referral of clients requiring specialist services, AOD policy makers have more recently seen generalists as being able to provide a cost effective, skilled, accessible and less stigmatised service to people with potentially harmful levels of AOD use. Current AOD plans, therefore, stress that the generalist has a vital role in providing brief/early intervention and health promotion services.

AOD plans also identify priority generalist workforces as those in primary health care and welfare. For primary health care workers, the most recent plan has set goals to increase their roles in:

- smoking- and tobacco-related interventions;
- alcohol-related interventions;
- illicit drugs; and
- pharmaceuticals.

Within the primary health care workforce, doctors and especially GPs are seen as highly credible and able to reach a wide population.

Nurses are seen as the largest group of health professionals involved in the management and treatment of people affected by alcohol and other drug-related problems. They are seen as having the capacity to assess and intervene at appropriate times in an opportunistic way which will assist to change or reduce drug-use problems through brief and other interventions (De Crespigny, 1992).

On the other hand, welfare and community services workers are targeted only for intervention in alcohol-related problems. While these professionals can demonstrate large numbers of alcohol and drug-related problems in case-work, they are seen as reluctant to intervene (Hands & Hamilton, 1994, p. 16).

In both the primary health care and community services workforces, women are the majority of workers. Women themselves are also strong users of the services provided by primary health care and community services workers. The provision of assessment, screening, early intervention and prevention services in AOD by a large feminised workforce well used by women, seems to present an ideal resource for working with the many levels of women's AOD problems.

However, despite signs in some areas that this potential is being realised a number of serious constraints still work against these feminised workforces delivering effective AOD services to women.

A major constraint arises out of the variable performance that each workforce exhibits in relation to developing both AOD education and training, and the conditions for allowing workers to use their AOD skills in the workplace. For those workforces which have developed education and training power imbalances specific to women, appear to keep them from fully integrating women's AOD issues into their education and training. Women and women's AOD issues are, for example, marginalised in National and State AOD plans. There is also a lack of information and consultation on women's AOD issues -- this being reflected in a serious lack of research on women's AOD issues and problems.

The net effect of these constraints means we suspect that, despite some encouraging signs, women's AOD issues are not being taken up comprehensively in the education and training of generalist workforces. At the same time it is difficult to comment authoritatively because there is not enough research being done on women's AOD issues or on the education and training of a wide range of generalist workforces.

The following is therefore an attempt to explore what is happening to women's AOD issues in the education and training of doctors, nurses and community services. A way forward is then suggested with some specific recommendations.

II THE PLACE OF WOMEN

In Australia, women are the majority of the population (52%) and live longer than men. Despite this majority status, unequal power relationships between men and women continue to exist in social settings, the workplace, the family and education.

For women, gender relations at the social, institutional and individual level tend to involve some degree of "power imbalance, exclusion from decision making in many government policy and community activities (lack of information and consultation, marginalisation) and cultural domination" (Barlow & Junor, 1993 p. 38). In the AOD area this power imbalance is reflected in quite a marked way.

1. Women marginalised in national and state AOD plans

Historically, the management and development of AOD policy and services at both National and State levels has been located in the departments of health. The AOD plans and strategies generated by these departments are gradually being influenced by major changes in health policies. Included in these policies is the women's health plan which is built on world health principles. This places women's health in a socio-economic context while recognising that differences in health are linked to differences in, for example, socio-economic status and gender.

Both National and State AOD plans refer to women as a special group. And so despite the majority population status of women, as well as their longer average life span compared to

men and developments in womens health, women are not seen as part of the normal group with AOD problems. Instead women have been added at the margins. Such a definition conveys a very strong message that women are additional and perhaps a bothersome extra to the AOD area. It also reflects the powerful gender stereotypes that exist about women's and men's Alcohol and Other Drug use in Australia. These stereotypes seem to condemn, minimise and ignore women's AOD problems.

2. Research on women's alcohol and other drug issues is only just beginning to emerge

Research on alcohol and drugs has historically failed to differentiate between men and women. As a result, treatment and prevention models developed for use by both specialist and generalist workers which are assumed to be accessible to both women and men are likely to be exclusionary of women (ie. half the population's needs). This trend is now slowly changing.

The prevalence of the harm associated with women's alcohol and other drug usage is now a matter of controversy. Women researchers responding to the allegation that men suffer the "greater proportion" of the harm associated with AOD consumption respond by saying that women's harm is qualitatively different than that of men. In a recent "Connexions" edition on the topic of women and drugs, Dr Dorothy Broom from the National Centre for Epidemiology and Health said she questioned the way in which alcohol and other drug harm is measured. She noted, for example, that breast cancer as an indicator of harmful alcohol consumption had not been developed.

In response to the same issue, Margaret Sargent (1994) concludes the following about the prevalence of AOD-related harm among women:

a). In the case of certain drugs (prescribed, over-the-counter, analgesics, and psychotropic drugs), the problems caused to women have been greater than to men for decades.

b). In the case of other frequently consumed drugs (tobacco and alcohol but not including marijuana), the trend observable in national research suggests that young women are as likely in the future to have as least as many social problems as men."

Research has also emerged to confirm that women's AOD problems are often severely stereotyped in the general community and even in specialist services. On one hand, women with hazardous alcohol and illegal drug abuse problems are considered more pathological than their male counterparts (Alcohol and Drug Foundation Victoria, 1992 p. 5). On the other hand, women with harmful levels of medications and tobacco use are often ignored because this is almost socially legitimate.

Women's needs in treatment and prevention are also being explored to see how they are different to those of men. For example in relation to treatment, it has been maintained that "because women have fundamentally different gendered experiences of being in the world than men, therapy cannot be effective or appropriate unless it proceeds from an awareness of

this and the factors in womens lives which underlie their drug and alcohol use, including their experience of physical and sexual violence, and their psychological sequelae" (Alcohol and Drug Foundation Victoria, 1992, p. 7).

For this reason many researchers have argued the need for separate AOD services for women, and those which are preferably staffed by women.

Less research appears to have been carried out on women's AOD issues in prevention. However, some of the research indicates that here again women's inequality in the family and society remains an important factor to consider. For example, Greaves (1990) concluded that:

> "to deal effectively with both the dependency and control needs expressed by these women smokers, prevention and cessation materials must convey a fundamental respect for girls and women... It is important to recognise the social and political inequality within which women exist, and to contextualise prevention and cessation programming within such analysis" (Alcohol and Drug Foundation Victoria, 1992, p. 14).

A recent *Connexions* article on women and drugs which reports some of Dr Dorothy Broom's thoughts on the issues of women in prevention programs notes that:

> "The role a woman plays in society and how far her worth is assigned has had an impact on the development of prevention programs. Dr Broom finds campaigns persuading pregnant women to stop smoking and drinking for the sake of their unborn child disturbing. As women frequently drink or smoke in response to the stress and dissatisfaction associated with their roles as mothers and nurturers, these campaigns only reinforce the beliefs that create the problem" (Major, 1994, p. 9).

II WORKFORCE'S RESPONSE

The overall response that generalist workforces have to clients with AOD problems has significant implications for womens AOD issues being dealt with effectively. A consensus in the literature substantiated those factors that prevent nurses, doctors and social workers from responding to AOD problems in their work. These are through the worker perceiving that they may lack:

- Role adequacy: enough knowledge and skill to respond;
- Role legitimacy: being certain about the right to intervene in an area considered to be specialist;
- Role support: having access to specialist support that can give support and advice; and
- Situational determinants: having working practices that recognise the importance of alcohol and other drug problems (Nixon, 1993).

In addition to the above, emerging research on women's AOD problems suggests that a further step is needed if women's needs are to be adequately met. To be effective, generalist workers should differentiate women's AOD problems from men's, and in particular they must deal with issues to do with women's social inequality.

If we apply the above factors to women's AOD issues, the following questions may be generated:

- Do workers feel confident in responding to women's AOD issues? Are they given information and knowledge about women's AOD issues throughout their training?
- Does the world view upon which their curriculum is based allow for a consideration of social and power relations issues?
- Are they given skills-based training around the AOD problems that women clients present in early intervention, prevention and treatment?
- Does their work role legitimate working in a different way with women? Would it allow for social and systems' issues to be taken into consideration when working with clients and patients?
- Are generalist workforces able to access specialist support competent in the delivery of AOD services for women within or outside their workforce?
- Do any of the protocols and procedural infrastructure surrounding AOD allow for women's AOD issues to be differentiated and acknowledged?

Within the limits of this Issues Paper, and given the lack of research available on this topic, it is difficult to respond to the above questions with any depth of data or analysis. Instead, a set of observations have been made which allow at least a tentative exploration in relation to the questions raised.

1. Are generic curriculum models serving women?

The integration of women's AOD issues into the education and training of health workers and community services workers may have been delayed or blocked by the dominance in the late 1980s of medically influenced "generic" curriculum models. During this time generic curriculum models were used as frameworks upon which the generalist workforces could build their AOD curriculum and training. During the late 1980s and early 1990s, many disciplines and workforces appear to have aligned their education and training to a medically influenced framework. This framework was noticeably silent on social and women's issues.

A 1987 national task force on education and training recommended that all education and training of generalist workforces should produce knowledge of:

- students own values and beliefs;
- current terminology and concepts;
- the complex causation of alcohol and other drug use and consequent problems;
- the effects of alcohol and other drugs on organs and systems;
- assessment, treatment and rehabilitation resources in the community for alcohol and other drug dependent people and their families;
- the physical, psychological and social effects of drug use including hazardous, dysfunctional or harmful use (including HIV/AIDS and hepatitis B);
- counselling and history-taking techniques;
- client legal and ethical rights and care-giver rights and obligations; and
- personal limitations and the role of the police and courts (Taskforce on Training Requirements of Professionals, 1987).

Women's AOD issues would have been better served if the "generic" curriculum had been built on the social framework proposed by Margaret Sargent two years after the 1987 taskforce. Sargent argued that appropriate frameworks for educating and training welfare workers and most health workers are in the social sciences. She argued for social frameworks broad enough to incorporate relevant biological or medical factors (Sargent, 1989p.154).

The following social work and welfare theoretical frameworks were identified by Sargent as highly relevant to AOD-training development for generalist health and welfare workers:

- systems theory;
- social deviance approach;
- social constructivism and historical approach;
- labelling and social control; and
- political economy.

Using these frameworks, generic curriculum content for educating and training generalist workers would differ from that arising from medical models. For instance, curriculum would include input on cultural differences in consumption between men and women, as well as the need to consider "historical and contemporary relations of power and economic conditions.." (Sargent, 1989 p.157).

A recent Melbourne University AOD project proposal (Hands & Hamilton, 1994 p. 17) reflects that the historical clash of packaging of AOD problems is still a current issue:

> "Resources for the prevention and treatment of alcohol-related problems have traditionally been directed at the individual...recent initiatives that adopt a systems' perspective more accurately reflect the complexities involved in the development of alcohol-related problems; in doing so they increase the likelihood of successful interventions and facilitate the inclusion of programs that are sensitive to community needs."

The introduction of the public health model and more importantly a growing sophistication with its implementation is changing the polarisation described above. Nonetheless, it is probable that higher education, workplace training and government bodies funding education and training were strongly influenced by a medically influenced model that ignored social issues and was silent about women in AOD.

2. Doctors

Several informants reported experiences to do with doctors and GPs not picking up on women's AOD problems. An AOD project officer working on women's AOD issues described the following situation:

> "Women in recovery in this area have said to me that there were many times when seeing a GP they disclosed information about their alcohol use and the doctor didn't pick up on the hazard. We're trying to look at what we can put in place in doctors' surgeries to alert doctors and women to women's AOD issues. I think for many of

these women they had so many issues they were presenting to the doctor that he/she would probably stick to the ones they could handle..."

A nurse noted that:

> "... at the ante natal clinics a lot of doctors don't ask women about alcohol and other drug use. Taking a simple AOD history will enable the woman patient to disclose use, provided it is done in an empathic way. By asking the questions we give the women permission to disclose, women are not always assertive about their problems. An interview gives clues..."

These situations continue to exist despite the fact that AOD education and training for undergraduates and GPs have developed substantially. A 1986-87 taskforce on training recommended as a priority, in comparison to other workforces or disciplines, the establishment of specialist education and training for medical students. This commitment was then followed through with the establishment of alcohol and other drug co-ordinators in medical faculties.

By the early 1990s, researchers such as Anne Roche and Professor John Saunders were outlining developments in AOD education, as well as highlighting improved prospects for the "prevention and management of substance use disorders". They identified the major determinants of effective practice behaviour as knowledge level or positive attitudes to alcohol and other drug affected patients, skills-based competence, self efficacy (role confidence) and realistic expectations of response to intervention. They described a model of effective drug and alcohol medical education in the following way:

> "On the basis of a certain level of knowledge and competence in clinical problem solving, instruction in specific interview and intervention skills is provided. Such input is designed to establish a high level of self efficacy amongst students and realistic outcomes of intervention. Thus, students will be provided with a sound basis for responding to patients with substance abuse disorders. Whether they do so or not when they practice as qualified doctors depends on their sense of role legitimacy. The latter will be influenced by a range of factors, e.g. the corporate ethos of the teaching hospital, expectations of patients and the remuneration basis for intervention."

Drug and alcohol education and training in medical curricula was also found by Roche and Saunders to be well served by an integrated curriculum model combining elements of behavioural science, pharmacology, public health, psychiatry and internal medicine. Problem-solving approaches were also used in clinical issues and were introduced early where the role of substance-use in disease and suffering could be identified (Saunders & Roche, 1991).

At this stage most of the literature on doctors' AOD training does not refer explicitly to women's health plans as having an impact on the medical curricula.

A closer look at more recent research and curricula indicates that medical educators are attempting to pick up on the small amount of medical research on women's AOD issues. Women's AOD issues, for example, are integrated in Roche et al's survey of AOD-related Knowledge and Attitudes of Family Medicine Programme Trainees (1993). In this study, two-

thirds of respondents overestimated safe alcohol consumption levels for general females (not in pregnancy). Topics to do with licit and illicit drugs in pregnancy, as well as levels of safe alcohol-use for women, appear in curricula materials.

It also seems there is some capacity for allowing women to be differentiated in skills-based training. An example of this was found in the Newcastle University medical curriculum where medical trainees are asked to role play and assess a male and female vignette around the theme of detecting and treating minor alcohol problems (University of Newcastle, 1993).

Overall, however in the same curriculum, topics or a discussion of social issues to do with women's AOD problems such as stereotyping, patterns of use, social roles and expectations, and their link to interventions are not immediately apparent.

3. Nurses

There have been substantial developments in providing AOD education and training to nurses. Furthermore, recent moves toward defining a nurse's role as health advocate, as well as the presence of specialist AOD nurses committed to exploring womens AOD issues, seem to provide a promising base for addressing women's AOD issues.

The 1986/87 Ministerial taskforce on education and training clearly identified nurses as a priority group for AOD education and training. Examples of education and training programs for nurses include:

- NSW: NSW Nurse education project, NSW Drug and Alcohol Directorate;
- SA: SA Nurse awareness program, Drug and Alcohol services program; and
- WA: WA Drug and Alcohol Service Nurse and Other health workers' education and training program.

Strategies used by nurses to educate and train on AOD include:

- the development of state-based strategic plans;
- the setting of client management protocols;
- the development of workbased training; and
- the surveying of knowledge and attitudes.

Informants in NSW say that progress on implementing these plans in NSW appears to vary. Some area health regions are performing better than others.

Again some informants and some of the research indicate that for nurses there are still difficulties in generalist nurses giving non-judgmental care to people with AOD problem. One interviewee described the classic attitude of nurses to AOD patients as being that they had been once "robbed by a junkie" and that every "heroin user is a robber". Other nurses expressed concern around the notion that generalists may not want to accept the "emotional" things that go with AOD. Nurses working with heroin-dependent women also suggest their colleagues often have quite strong values and beliefs about pregnancy. For example, there is a belief that heroin users are not good mothers, should not be pregnant and so on. Goodin (1992, p. 78) noted a problem for nurses in the pattern of psycho/social training in

undergraduate education being lost when nurses hit the "hierarchies" and "biotechnical" culture of the ward.

Goodin added that there was a need for further research into nurses and the extent of their early intervention role. Despite being targeted for a role in early/brief intervention and prevention nurses were not as yet good at working on a continuum of severity and, therefore, the possibility of change in a patient with harmful levels of AOD use.

The sparse- to non-existent Australian research on the education and training of nurses in AOD hampers our ability to understand how their role in AOD is developing and wether it does deal with womens AOD issues. Little, for example, is systematically known about the nature of AOD curricula developed and implemented for undergraduate nurses.

On the other hand, there are very promising signs that in today's context nurses are moving away from and debating medically based models of education and training. As nurses moved into a higher education sector the questions *what is nursing? is it an art? is it a science? how can nursing be defined as a discipline?* are starting to impact on the issue of where AOD belongs in the curriculum (Goodin, 1992, p. 75).

De Crespigny (1992) describes the role of a nurse as:

> "...primarily that of health advocate. Nursing skills and knowledge are drawn from the social and bio-physical sciences. Nursing care involves the facilitation of holistic health care for individuals and the community. It is their role as advocate that identifies nurses as vital to the implementation of the processes of health promotion and maintenance in the Australian community".

She also describes the role of a nurse as community worker:

> "Part of nursing role is to ensure the effective communication and transfer of information through collaboration with other nurses, allied health/welfare workers, individuals, families and communities."

Such reappraisal of nurses' role will allow nurses to legitimate their involvement with women's AOD issues and will provide educators with a framework that will allow for more complete consideration of women's AOD issues.

There are also tangible signs that nurses reflect on and integrate women's AOD issues into their training on AOD. Examples include:

- a Flinders University graduate certificate in health for nurses in AOD now includes a module on women and drugs;
- a recent Drug and Alcohol Nurses Association (DANA) conference which explored different approaches to women and dependence. Topics included women in non-medical detoxification, mothers and women in our society dealing with the substance-abuse problems of young people and women that love too much (or men that don't love enough); and
- a proposal to research nurses: ie. women's own AOD use.

This is not to say that women have featured significantly in the full range of education and training strategies adopted by nurses. In NSW, for example, the nurses' AOD education unit reports that while women are seen as a special category there have not been the resources to delineate between men and women in, for example, clinical case management guidelines.

4. Community services

Virtually nothing is systematically known about AOD work in community services settings and how women's AOD issues are or might be treated in that setting. There are no sector-wide education and training projects or strategies. Similarly, few research projects have been established to examine links between AOD, family violence, family support, domestic violence and sexual assault. In a project proposal to look at the presentation of alcohol in welfare settings, researchers have noted that:

> "little is...known or documented about the willingness, expectations, attitudes, knowledge and skills of these (welfare workers) to intervene or of the organisational context which might facilitate such activity" (Hands & Hamilton, 1994).

For women's AOD issues this has been an enormous opportunity missed given that many welfare, social work and counselling courses are able to deal well with women's inequality and strategies to address this inequality. In the field, a growing number of community services workers and professionals are employed in services which operate out of feminist philosophies and world views and which provide services of direct relevance to women. For example these workforces include:

- refuge workers;
- NESB women's refuge workers;
- sexual assault workers;
- welfare workers;
- family support workers;
- child protection officers;
- child welfare services; and
- youth workers.

The tragedy for women with hazardous levels of AOD use is that in many cases these services, which could offer them support on the basis of empowering philosophies for women, have been the services that have most rejected them. For example, in NSW women with hazardous levels of AOD may be rejected by women's refuges.

The reasons behind the lack of integration of AOD into community services workforces are not well understood. The following observations are made, however, in regard to this issue.

Community services and welfare workforces appear to have been substantially marginalised in research by the dominance of primary health care workforces. Again significantly for women, very little work (if any) has systematically examined opportunities and impediments of detection and early intervention in alcohol-related problems presented in the welfare sector (Hands & Hamilton, 1994, p. 5).

Reports on the availability of undergraduate education and training about AOD in community services vary. Sharpe (1992), commenting on this issue, says social work/community services workers receive little or no education and training in AOD and much of what is available has an elective status. Some of the reasons he put forward for this include the diversity of social work curriculum, the shaping of courses by the interests and talents of academic staff and a lack of field work placements. He also noted that courses which see the primary role of a social worker as a social change agent are unlikely to give priority to AOD which they perceive as a symptom of broader dysfunction.

Other research has found that community services workers were being trained or were training themselves in AOD issues. For example, Nixon (1993) found in a small survey of community services staff in Western Sydney that all but one participant had completed drug and alcohol education or training courses. For her sample she concluded that any failure to pick up AOD issues is not due to a lack of training.

On the other hand, a few samples of AOD training developed in a community services contexts seem to show a strong capacity to integrate social issues for women into education and training. For example, a "working with families of substance-abuse concerns" program at the University of Iowa covered the following topics:

- family systems concepts and practices;
- gender, non-traditional families and the "trapped underclass";
- addiction and the special characteristics of women with substance-abuse concerns;
- drug-exposed children (their needs and care);
- systemic interventions; and
- recovery relapse spirituality (National Resource Centre for Family Based Resources on Family Based Services, 1992).

Similarly, a community services worker commenting on AOD training for her area said:

> "Models that look at women's AOD issues in the context of her role as primary care-giver and, therefore, the consequences of her actions on others, fail to look at the male as care-giver and the consequences of his substance abuse or his behaviour. If it's her direct care-giving that causes children harm then it could be said that she's a product of his care-giving actions too. His actions have consequences.
>
> "Agencies fail miserably in taking men on; they are just seen as too hard, bad or ugly; we continue to work with her to come up with the solutions; we ignore the political nature of the problem; he is seen as too difficult; he might be too tall or too strong or just too unwilling; I see it over and over here if he won't come we'll accept that we'll find excuses like he's working; he thinks it's silly; he feels threatened; but if she doesn't turn up at one interview we'll take the kids away from her; women's problems are not being seen in the context of the family; it is a mistake to talk about women's problems in isolation."

Overall, however, attitudes and values of this workforce in regard to women's AOD issues may be seen as reflecting those of the nurses and doctors prior to any AOD education and

training. Informants reporting on community services workers suggest that many attitudinal shifts are still needed about AOD and about women and AOD in their workforces.

There are suggestions that community services workers still have a lot of anxiety about AOD. They feel they cannot touch it unlike, for example, domestic violence. Their immediate response is to find someone else who can. Informants report feelings of fear and repulsion. As a part of such a response it has been remarked that women often receive an extreme moral judgement that they are "bad". Some community services workers have also been described as being "off" with their treatment of people, and so alienating the client presenting an AOD problem. In these kinds of situations, clients may stop asking for help -- perceptions being that men will often bluff their way through the problem while women won't be so demanding and will often just "slink away".

Women with hazardous levels of AOD use may still be seen by some community services workers as acting against the female stereotype of mother and care-giver. A woman who loses control of a substance is considered pathetic. Such condemnation appears to vary depending on the type of substance a woman uses. Women with hazardous levels of alcohol and heroin use are seen as worse than those with medication problems. There are also indications that community services workers trained to support women in their parenting role, when faced with a substance-abusing woman with children, will panic because of feelings of judgement. A very quick conclusion may be reached that women with AOD problems should not be responsible for children.

As recently as 1992, for example, Dr Grunseit, a child protection council chairperson, reflected some community services workers' judgmental attitudes to parents (ie. women) with AOD problems by saying he did not believe abusers of alcohol and other drugs could be "good enough" parents. "Addiction is a way of life for the addict," he said. "Drug and alcohol abuse invariably results in children being at risk of deprivation abuse and neglect" (NSW Child Protection Council, 1992).

Many informants reported that community services workers are not approaching women clients with hazardous levels of AOD as they have been trained to do so in their occupation. One reason for this may be that a community services worker may perceive they do not have the basic skills and knowledge to deal with AOD-client problems.

A NSW family support worker interviewed for this Paper suggested that FSS workers view AOD as too technical. They are put off by the language and are concerned that it is a health issue and not their issue. As a result, some FSS workers take the position that they will not work with anyone with a drug problem. This same worker went on to describe the FSS worker's response to AOD in the following way:

> "They feel they just haven't got the experience... that AOD is one of those scary areas. They feel it's difficult to normalise behaviour when there are personality changes."

Many community services workers are also reported as being unaware of the changes in AOD such as the move away from the disease model to the harm-minimisation model.

There are also indications that women AOD clients are not getting assessments usually integral to the jobs of most community services and welfare workers. As a result, it seems that some women are being referred to specialists when they shouldn't be and some women may have their treatment terminated too early.

A further issue noted by some informants is that when community services workers do not take on women with AOD problems as their clients, treatment may become seriously split and messy for the woman. If community services workers do not take on woman AOD-abusing clients, the woman experiences the problem of each professional/worker giving her only part of what she needs. For example, one specialist informant described the problem in the following way:

> "In my area sexual assault workers will immediately refer a woman with an AOD problem. In our particular agency, on the other hand, we would suggest that the sexual assault worker work in consultation with AOD and not get terrified. AOD in this instance needs to be seen as part of the symptoms of sexual assault trauma. Women with AOD problems suffer from this need to compartmentalise. A woman needs to be treated as a whole person rather than bits of her shoved around."

The national strategy on preventing child abuse also notes that "the child protection field and the other services have been slow to incorporate knowledge from one another's areas into their practice. This has sometimes left clients having to compartmentalise their lives and treatment according to program descriptions rather than their needs" (National Child Prevention Council, 1992).

III A WAY FORWARD

The above list of working observations is an indication that women's AOD issues are not penetrating the AOD curriculum developed for generalist workers. It is also apparent that the majority of the generalist workforce are women and therefore may themselves have different needs to men in relation to how AOD curriculum is designed and developed. However, for women it is not enough that there is a commitment made to "equity" as is the case in national generic curriculum guidelines arising out of a national cross-disciplinary workshop in 1992.

Because women are half the population and because their AOD problems are sizeable and different, women's AOD issues need to be integrated in a more thorough and explicit way into the professional development of generalist workers. Women's needs as learners also need to be taken into account when education and training are designed. The following are a set of more specific suggestions for how the latter might be achieved.

1. Gender inclusive curriculum

A more powerful gender sensitive conceptual and planning tool may be needed if we are to achieve gender equity for women in AOD curriculum and training for generalist workers.

In the vocational and training sector, this tool is referred to as gender-inclusive curriculum which questions the construction of gender identities (Barlow & Junor, 1993). It acknowledges

that action needs to be taken to avoid contributing to power imbalances between men and women. It seeks to lift some of the limitations of choices available to men and women through the segmentation of men's and women's behaviour.

Synthesising the published literature on gender and curriculum, Porter (1993) has developed a typology of curricula as:

- womanless (gender exclusive) unconscious exclusionist processes at work even though curriculum appears accessible to all;
- adding women at the margins. Women are seen as special but not seen along with men in different age groups and cultural and language backgrounds as the "normal" learners for whom the curricula is designed;
- treating women rather than the curriculum as the problem. In male-dominated areas, women are seen as "additional" and therefore the problem rather than the curriculum is the problem;
- treating women as different. Because inequalities between men and women have not been redressed and because there are differences, it continues to be necessary to recognise women's differences; and
- gender fairness extending the repertoire of behaviour for both women and men, as well as working off the premise that we need to change the mainstream in order to reflect new definitions of the normal worker, client, learner, etc.

At present, AOD curricula for generalist workers appears to be integrating women's AOD issues by adding women at the margins. It would seem that a movement is needed towards a comprehensive overhaul of curriculum to reflect what is known about womens' differences. Once such a strategy is adopted, the entire curriculum may change to reflect a broader set of issues for both men and women. It would, however, be foolish at this stage to lose the focus on women's AOD issues.

An important outcome of the Gender Inclusive Curriculum research project (Barlow & Junor, 1993) was the development of a set of gender-inclusive principles to guide curriculum. These principles, as follows, are relevant to both the issue of women in the curriculum and the issue of women as learners:

Access: For example, barriers to access based on gender and gender-related factors need to be overcome such as delivery modes, timetabling and access to resources. Positive measures are taken to encourage women's participation in non-traditional areas. Language and terminology do not present barriers to women.

Equity: For example, opportunities for credit transfer and career-pathing are comparable across industries and occupations.

Participation: For example, gender is included as a curriculum topic. There is provision for reflective consideration of gender and power relations in teaching, learning and employment while the analysis should contribute to an understanding of the way men are privileged by existing language, practices and structures.

Representation: For example, women with relevant expertise in gender justice should be involved with each stage of the curriculum development process. Curriculum should reflect the life experiences of both men and women while language and terminology must reflect the competencies of women.

Recognition: For example, prior learning is recognised.

Outcomes: For example, multiple exit points with a range of vocational outcomes and multiple entry points while providing vertical and horizontal pathways for transitions for women.

2. Hallmarks of gender inclusive AOD education and training for generalist workers

At this stage it might be important to create a vision of some beginning hallmarks of gender inclusive AOD education and training for the primary health care and community services workforces. Such education and training would:

Be examined by its developers for gender equity
In the process of being developed curriculum would be examined for its gender equity towards women's AOD issues and women as learners. For example, all attitude and knowledge surveys should be checked for women's AOD issues. Surveys on delivery modes would take into account how women and men prefer to learn and what conditions might impact on how they learn.

Integrate women's AOD issues throughout the curriculum
Women's AOD issues would be integrated throughout the curriculum and at strategic points. If there are distinct modules on women's AOD issues they exist to reinforce knowledge and skills being developed throughout the curriculum on women. For example, women's AOD issues should be made explicit in any formal or informal assessments

Challenging myth/values about women's AOD problems
Historical and social perspective and content on women's AOD problems would be developed and integrated throughout the curriculum.

Using accessible language
The language surrounding AOD would be de-medicalised and put into plain-English as much as is possible.

Package AOD issues and problems in a way that suits women
Knowledge, role plays, case studies and models of intervention referred to would allow for women's AOD problems to be put in the context of women's changing role in the family, in society and in the power relations between men and women. Knowledge is drawn from projects that have addressed women's alcohol and drug use in an historical and social context and which have considered the issue of the meanings of drug use instead of a simple focus on the individual. Data drawn on may come out of sociological, anthropological and historical analysis and would be inclusive of the diversity of women in our society -- NESB women, aboriginal women, women with HIV, gay women and so on.

Emphasise early intervention and prevention

The research indicates that women's hazardous and harmful levels of AOD use are well-suited to early intervention and prevention approaches. Models that kept away from overly simplistic and brief approaches to the latter are needed.

Promote a component of cross-sector delivery

A holistic consideration of women's AOD issues would be enhanced if at least one component of training is delivered in cross-disciplinary settings. Individual agencies, the state government and generalist workers need to combine areas such as child protection, sexual assault, domestic violence and AOD issues from time to time in joint training strategies.

Include on-the-job learning

A curriculum focusing on attitudinal and role changes requires for its effectiveness some type of workplace training. Women workers currently in the workforce will benefit from structured on-the-job learning such as work shadowing and on-the-job training contracts. Action learning where small focus groups reflect on their actions and the changes required in themselves and their organisations to work effectively with women's AOD issues are also used.

Use flexible delivery modes

A range of learning styles is accommodated with acknowledgment of the differences between workforce cultures, men and women and social cultures. For example account is taken of the diversity of learners roles in work and outside of work in the timetabling and delivery.

3. Specific actions that could be taken to address some of these issues.

The following are a set of recommendations for actions linked to strategic developments in the field of AOD education and training:

1. Work in progress in the development of AOD competencies for generalist workforces should be reviewed by an expert in gender justice for women in the AOD area. Examples include the development of AOD competency standards in the NSW TAFE system for community services worker and work in SA on the development of AOD competencies for nurses.

2. National drug dependence bodies to provide funds to the National Community Services and Health ITAB to assist in the development of generic AOD competencies and the development of an AOD education and training plan for community services workers.

3. Officers in the NSW DAD working on the development of a task force, strategic plan and education and training board, should be alerted to the need to fully incorporate gender inclusive principles into the setting up of the board, the development of any generic curriculum criteria, planning, etc.

4. Impact and other types of evaluations of AOD education and training, eg. the nurses' plan in NSW should be gender-inclusive and monitor the inclusiveness of their curriculum for women.

5. NCETA to commission a cross-disciplinary group of women working on women's AOD issues to develop a set of gender inclusive curriculum guidelines for those developing AOD education and training.

IV CONCLUSION

Despite some promising signs women's AOD issues are still not comprehensively integrated in the education and training of doctors, nurses and community services workers. A way forward may be found in the model of gender inclusive curriculum being developed in the vocational sector. Using this model and what we have learned about women's AOD issues it is possible to develop at least the beginning hallmarks of a gender- inclusive generic AOD curriculum model for health and community services workers.

This paper will have achieved its purpose if it prompts discussion and debate on these issues which lead to the further integration of women's AOD issues in the education and training of the health and community service workers.

APPENDIX

Terms

The term "Other Drug" in this Issues Paper covers all licit, recreational over-the-counter and prescribed medicines, as well as illicit medicine and tobacco.

References to "harmful" use and "hazardous" use are applied where possible in place of the more common references to "drug or substance misuse and abuse". Research on terminology in the Alcohol and Other Drugs (AOD) area indicates that when the latter references are used the negative and personalised aspects of alcohol and other drug problems are reiterated (Pols & Hawks, 1992).

In this Paper, the term "informants" refers to professionals interviewed by the author in response to women's AOD issues in the workforce. This group is made up almost entirely of women professionals who were able to share their knowledge or experience in working with women's AOD problems or able to provide a close perspective of how their generalist workforce (for example, community services) dealt with women's AOD issues.

For an explanation of the term "generalist worker" see the Paper's Introduction.

Approach

Data for this Issues Paper has been initially gathered from a brief review of the literature pertaining to generalist workers. As a way of generating issues and further conceptualising this topic, over-the-phone interviews were carried out with specialist and generalist workers. The majority of these "informants" were chosen on the basis of their interest and work on AOD issues for women; some come from a particular generalist workforce (eg. child protection and family support).

Nearly all literature concerned with the topic comes out of the medical arena and is concerned with the education and training of undergraduate medical students, and in some cases GPs. Literature arising out of nursing and community services/welfare contexts is sparse to non-existent. In both the medical and community services sector very little of the literature deals with women's AOD issues in the education and training of health/community services workers.

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RURAL/REMOTE WOMEN: DRUGS AND ALCOHOL

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I wish to gratefully acknowledge the general information and statistics provided on Queensland by Epidemiology and Health Information Branch of Queensland Health, on South Australia by the Drug and Alcohol Services Council and on NSW by the Drug and Alcohol Directorate of the NSW Department of Health.

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All figures and tables referred to in this paper may be found in Appendices A & B respectively.

EXECUTIVE SUMMARY

This paper brings together available statistics on women's drug and alcohol usage in rural and remote areas. It also outlines a service delivery oriented rural and remote area classification for Australia, the key types of communities that exist in the rural and remote areas, the differences in the way smaller rural communities function, and a summary of models and principles considered important in servicing such areas.

It is argued that it is not sufficient just to know women's drug and alcohol usage patterns and it is also important to understand how isolation and small community size works to include and exclude different women, to exert social pressure and to limit choice. Moreover, the place of alcohol in the culture and social interactions of the community is an important consideration in how services should work.

Overall, Queensland and the Northern Territory have the most information at a regional level on the alcohol use of women. Information on other drugs is very sketchy. It appears likely that it is women in the north of Australia in leisure oriented Meccas and in the remote areas that are most likely to drink at harmful levels. The results on tobacco smoking are sketchy and confusing.

Service delivery reports emphasise the necessity of using multi-skilled generalists to ensure services are present in small population centres or of sending out visiting specialist workers from the larger regional home base. The former, though attractive has a lot against it in practice. In any case, neither should be costed as a cheap option because rural and remote workers need high quality training, supervision and resource back-up to deliver good services. The lack of these things is the key finding of one of the few studies done on rural drug and alcohol services.

The last section suggests key principles to consider when deciding services and gives some recommendations for research - an intensive ethnographic study of rural women's drug and alcohol usage and a survey of the drug and alcohol profiles of women in several different types of communities which can be updated every five years.

I INTRODUCTION

Because so little is known about rural women's drug and alcohol-using habits and about the issues involved in addressing them in rural and remote communities, it was decided to gather together whatever qualitative and quantitative information existed. Three major areas were investigated: rural women's drug and alcohol usage; the social context of women's lives in rural and remote communities; and service delivery issues which might be relevant to the provision of drug and alcohol services. Finally some suggestions will be given for further research work and policy and service directions in order to stimulate discussion.

The structure of the paper will be as follows,

- a classification of rural and remote areas,
- a brief outline of the major types of communities contained within that classification,
- a review of what is known empirically about rural women's drug and alcohol use and abuse in rural and remote areas,
- a summary of key social processes affecting women's lives in smaller rural communities,
- a summary of service delivery issues and reports on rural drug and alcohol workers,

and finally,

- principles to keep in mind when planning and delivering drug and alcohol services to rural and remote women and some suggestions for further research.

Rural and Remote Australia: A Classification

There are, at present, two major classifications of Australia's rural and remote areas: one developed by the Commonwealth Department of Primary Industries and Energy and the other by the Department of Human Services and Health. Both are based on density of population as measured by Statistical Local Area population data and distance from a capital city. In this paper, the classification developed by the Department of Human Services and Health will be used, because it has been developed specifically with the need in mind of providing a base for the assessment of health and welfare services, especially in terms of access and equity considerations (DHS&H 1994, 1).

In this classification Australia is divided into seven categories:

1. Capital City
2. Other Major Urban
3. Rural Major
4. Rural Other
5. Remote Major
6. Remote Other
7. Other Offshore Areas

The ***Capital City*** category includes all the SLAs in the Statistical Division of each State and Territory capital city.

The ***Other Major Urban*** category includes all SLAs which form part of a non-capital city urban area with a combined population exceeding approximately 75,000.

The ***Rural/Remote*** classification. A rural SLA is generally one within a few hundred kilometres of a capital city or major urban centre. A remote SLA is one that is not within reasonable proximity of a major urban area, or one that has significant physical barriers separating it from such a centre. SLAs on the borderline of Rural and Remote are generally classified as Rural.

The ***Major/Other*** classification is based on population density and size. The SLAs are classified as Major if they meet the following conditions in the following States:

NSW population approx. 20 000 (or 10 000 and 30 or more per sq. km)
VIC population approx. 20 000 (or 10 000 and 30 or more per sq. km)
QLD population approx. 18 000 (or 9000 and 30 or more per sq. km)
SA population approx. 14 000 (or 7000 and 30 or more per sq. km)
WA population approx. 14 000 (or 7000 and 30 or more per sq. km)
TAS population approx. 14 000 (or 7000 and 30 or more per sq. km)
NT population approx. 14 000 (or 7000 and 30 or more per sq. km)
ACT population approx. 14 000 (or 7000 and 30 or more per sq. km)

Those areas that fall outside these population densities and sizes form the 'Other' category.

The ***Other Offshore*** Areas classification comprises the areas allocated in the Australian census statistics to the category 'Offshore areas and Migratory'. It should be noted, however, that some islands are SLAs in their own right and have therefore been classified as ***Remote Other*** (for example, King Island).

Although such classifications, once made, suggest that there are clear-cut differences between urban, rural and remote communities, this is not so. The concept of 'urban' refers to people living close together and having a way of life not linked to working the land. The usual understanding of the word 'rural' is that the people in such areas are using the land for pastoralism or agriculture (i.e. animals or crops). It also implies that there are more open spaces than in urban areas.

In contrast, the concept of remoteness has little to do with the industry in which people are engaged in or with how dense the population might be or what is the focus of their culture. Remoteness is simply a concept of distance and isolation. And, most importantly, it is a concept which betrays the capital city bias of most Australians because what is being alluded to is an area's remoteness/isolation from the resources available in the big cities. It is my impression after five years of field work in rural and remote areas that people tend to regard themselves as isolated or remote only inasmuch as they need or value those urban resources. This is a very important concept to grasp for this paper. It means that we have to think about remoteness differently for different groups of people. It is likely to be very different

for the essentially urban woman who might, for example, be raising children in an iron ore town in the Pilbara, or married to a property owner in the Unincorporated Area of NSW than it will be for the Aboriginal or non-Aboriginal woman in those selfsame areas who has grown up on her family's land or in her family's community, who has rarely, if ever, left it, and who wants little else.

There is also, in all the present classifications of rural areas, a huge problem that has never yet been addressed. What does one do with the highly urbanised coastal areas such as Port Macquarie, Ballina, Hervey Bay, and Cairns? Surely it is surely a misnomer to categorise them as rural! Yet, at the present time that is their classification. So by all intents this paper on rural women and their drug use should also deal with women in such areas as well. In a sense rural has become the classification for everything between the metropolitan and the remote areas irrespective of the dominant culture. For this reason I want to try to separate out the different types of communities in which rural and remote area women exist in order to give a better idea of the factors that need to be correlated with usage patterns and service delivery strategies.

Key Rural and Remote Area Community 'Types'

Contrary to the stereotypes often held by urban Australians, there is in fact a huge variety of people and lifestyles within rural and remote areas. For this reason it is useful to outline some of the main settlement patterns, population characteristics and economic and social forces that set the context for women's lives in rural and remote Australia. If one were to move out from any capital city (with the exceptions perhaps of Hobart and Darwin) along the coast and then make a line into the centre of Australia one is likely to encounter the following kinds of communities.

First, there are the coastal communities and other centres inland which are close to the metropolitan areas and which are aesthetically appealing and culturally desirable. These are often in old farming areas or are coastal holiday and fishing areas. They are often characterised by a greater movement of people in and through the area. Often there is a higher proportion of retirees or unemployed younger people and single parents who have gone there in search of a better lifestyle on their limited income. There is, in these areas, a mixture of women who are used to a metropolitan culture and range of opportunities and services and women who are used to a more rural culture, smaller communities and a lesser range of services. These latter are generally from inland areas or are long-term residents of the area. Often the rapid growth of these areas leaves service provision straining to keep up. Especially where the climate is warmer, young urban women and much older urban women with their typical profile of drug and alcohol use will be congregating. One can predict that women are perhaps more likely to be experiencing unemployment or underemployment and, for a period at least, a lack of social supports in the immediate area whilst they get to know new people. If they are in tourist areas the culture that goes with that industry will be affecting younger women in particular.

Moving inland we come across the more traditional farming communities. The settlement pattern becomes more recognisably one of smaller service towns interspersed with larger regional centres that act as the hub of economic and cultural activity in the region. These

mediate many of the influences that come from the cities into the region, especially the provision of human services, and people will often travel to these centres for shopping and services and perhaps recreation. Although population is far more scattered overall, there are still pockets of dense urban settlement where women are town dwellers as in any suburb. Now public transport is very sparse. Women in all but the regional centres are likely to be older, to have worked in a narrow range of industries - helping on farms, working as clerical or shop assistants, a few working as health or welfare workers or as teachers. Many will have been part of a small family business. In this region and in the regions that follow, a woman's economic opportunities are more likely to be dependent on those of the family as a unit or on those of the men in her family are more likely than in the metropolitan areas. Younger women, if they want to access greater opportunities, generally have to marry up or have to leave the smaller communities for the larger population centres. Most will not return, though they may, later, filter back to other rural communities because they are comfortable with the lifestyle. Regional centres may pick up a lot of these women in the long term. Those that are left will remain greatly influenced by the social mores of their town and will generally aim for the traditional roles available to women in their strata of society. The leisure patterns and coping patterns of the women in their town - which may be a little different according to age and life stage responsibilities - will influence their use of drugs and alcohol. This is the zone in which Ken Dempsey's piercing analysis of rural life in the 1980s, Smalltown (1990) took place. In this zone women say the towns are men's towns, though the proportion of men to women is not significantly different to the national average.

As the distance increases from the capital cities and one moves towards the Centre, one encounters next the marginal zones with their unreliable rainfall and more fragile ecosystems. Those sparselands have large pastoral properties and smaller urban settlements with long distances between them. There is a mixture of four major types of communities - the old and new mining communities, Aboriginal communities, old pastoral-based service towns and small groups of people working pastoral properties. Nowadays some of these are also involved in the tourist industry. These will generally range in population size from that of a family up to 24,000 people - though only four centres in Australia in the marginal zones are over 20,000. In these areas there can be huge variations in the income and background of the women and their families. Some women have access to large incomes and are directly connected to national and international interests. These are generally the Anglo-European women connected with the mining or tourist industries or with major government departments and services. Most of these women have a modern urban culture, lifestyle and set of expectations for services. However, there are also women who have lived most of their lives in the area and whose culture and social interactions are largely dictated by the older, more conservative frontier culture of the long-time locals. Although this is changing with the younger generation and the influence of the media, it is slower to change than metropolitan areas.

In these frontier zones that are marginal for European activities and settlement, culture is dominated by men's concerns and leisure activities to a greater extent than it is in metropolitan areas. Stories of outback women such as those collected by McCord (1986) emphasise women's own perceptions of such a life: that it is hard to keep up women's traditional home-based activities and social pursuits in this context and that both men and the land can be hard on women. Moreover, the proportion of Aboriginal to non-Aboriginal people rises sharply in these areas so that racial issues become important on a day-to-day

basis. Women in the remote areas are perhaps even more profoundly affected than elsewhere by the alcohol and drug-taking habits of men because isolation cuts down their choices. They are also highly dependent on the attitudes and advice of community nurses and medical practitioners - the latter of which are generally held in high regard and have great influence on the prescribed drug-taking habits of local women. There is a tendency for non-Aboriginal women to be in the child-rearing stage of life in remote areas - apart from in the older settlements, where it is mainly the older population which is left. Where mining is predominant, there are generally few women under 20 and over 50 years. However, there is always a more even spread of ages amongst Aboriginal women.

Food, consumer goods and power are very expensive in remote areas and women are even more dependent than in city areas on high salaries for a culturally acceptable lifestyle. Many non-Aboriginal women will be renting. Their activities and moods are more likely to be affected by extreme weather conditions. Most will be far away from their long-term social supports. Aboriginal women are likely to be experiencing around them (and perhaps participating in) a great deal of overt community violence and high levels of alcohol abuse.

As can be seen from this diversity, it is doubtful whether useful generalisations can be made about the drug and alcohol usage patterns of women in rural and remote areas. The drug and alcohol profile that belongs to, say, the Lismore and environs of retirees and alternative lifestylers is likely to be vastly different to that belonging to traditional rural towns like Cootamundra, and to the mining-based remote suburb of Tom Price and to the Gulf Aboriginal community of Booraloola. In all those places the socialisation, experience, pace, age and culture of the community and of the women in it and the availability of drugs are likely to be so different. In metropolitan areas, in contrast, the pattern is likely to be much the same (depending on the age of the woman) whether it be Brisbane, Melbourne, Perth or Hobart.

II RURAL AND REMOTE WOMEN'S USE OF DRUGS AND ALCOHOL

Alcohol

The National Picture

The place to start gathering a possible picture of rural/remote women's drug use is in the national picture. The national picture is contained in the analyses of National Household Surveys conducted on behalf of the National Campaign Against Drug Abuse (NCADA). However, this data cannot be divided into areas smaller than whole States so that it is not possible to pull out a picture of the drug and alcohol usage in a particular region or in the rural and remote areas as distinct from the metropolitan areas.

The same applies to research literature. A major review of all literature on women's substance abuse and treatment needs was written by Jan Copeland in 1994, but again it did not deal specifically with rural/remote women or service delivery. The major points to come out of that review were that harm reduction approaches and a less confrontative model of treatment than the supposedly male-oriented twelve-step approach were more suitable for women's treatment programs. Moreover, it was considered important ideologically to have

women-only treatment programs, with childcare facilities. These would provide a safer environment for women to discuss parenting issues, to get social skills and self-esteem training and to be able to work therapeutically with any history of physical and sexual abuse.

A report on preventing alcohol and drug related problems amongst women from the NSW Drug and Alcohol Directorate (Baily 1991) reviewed what was known of alcohol consumption amongst women in Australia by workers in the field. The following picture gathered from all these general sources is probably familiar to everyone in the field by now:

- Alcohol is of the greatest concern.
- Women's consumption of alcohol is traditionally less problematic than men's.
- It appears that there has been no significant increase in the overall percentage of women who drink.
- There is a trend for women in the 18 to 24 years age groups to be drinking significantly more than that age group did previously.
- Hazardous drinking in the 18 to 24 years age group has substantially increased since 1977. Women in this age group are more likely to exhibit a binge drinking pattern - on weekends in particular - whilst women over 35 years of age are more likely to experience problems related to regular use of alcohol.
- Wine and spirits are becoming more popular with women - the latter in the 18-24 age group particularly. Beer drinking is supposed to have decreased amongst women who are over 25 (Corti 1989; Hentlas undated; Corti & Ibrahim 1990).
- There is some evidence that girls of 14 and 15 years of age report drinking more heavily than boys (Baily 1991, 26).

But the big question is how accurate is this general picture in describing the situation of women in rural and remote areas? Is it in fact an urban-metropolitan picture masquerading as a national picture?

The Rural/Remote Picture

It is in the health statistics from Health regions that it is possible to get some comparisons of rural and urban alcohol intake patterns. However, these are generally only on the basis of hospital related data and pharmaceutical records and therefore indicate rather the level of harm to health that such usage generates than the level of usage. It is in Queensland, the Northern Territory and NSW that regional survey data is available to provide a clearer picture.

■ New South Wales

New South Wales figures reveal that there are wide differences in alcohol risk levels between some rural/remote regions. Women in the South East and Orana Far West Health Regions appear to have the highest alcohol risk levels (11 per cent and 9.2 per cent respectively,

compared with 5.4, 6.0 and 6.3 per cent for the South West, New England and Central West respectively) (Farrell & Wraight 1993, 57). This is based on average daily consumption during the week prior to interview.

There is also some evidence to suggest that the type of beverage preferred by women varies considerably between rural/remote and urban metropolitan areas. The consumption of full-strength beer was prevalent in all rural regions. For example, in the Orana Far West Region, 40 per cent of the alcohol consumed was full-strength beer and only 18 per cent was wine. In comparison, North Sydney was 44 per cent wine and only 29 per cent full-strength beer (Farrell & Wraight 1993, 57). There are also indications that Aboriginal women in NSW probably drink at higher risk levels than non-Aboriginal women: 16 per cent of Aboriginal females compared to 7.9 per cent of non-Aboriginal females (Farrell & Wraight 1993, 57). As most of the Aboriginal population is situated in rural and remote areas this also adds to the picture of higher consumption levels in some rural/remote areas.

■ Queensland

The best regional indicators of women ŕs alcohol use are available in Queensland. In 1993, eight hundred general health surveys were carried out by telephone in each Queensland health region (Figure 9). Questions were asked about alcohol consumption and the data divided up by gender as well as age. As yet, statistics from the major urban areas within each region have not been divided off from the non-urban areas, although such a division is presently being contemplated (Gabrielle Crook, personal communication). However, as some of the health regions are fully within the rural and remote classification used in this paper, the non-metropolitan regional figures generally reflect rural and remote area usage. Details of the survey methodology and the principles upon which the regional comparisons have been made are contained in the Queensland Regional Health Survey ŕs 1993 Inter-regional Comparisons documents. The major point that emerges is that there are some significant regional variations in reported nicotine and alcohol usage. These statistics alert us to the likelihood that in other States too there are likely to be significant regional variations in the pattern and prevalence of drug and alcohol use. The Queensland alcohol statistics, which are reproduced visually in Figure 10, show that the South Coast Health Region, a predominantly urban area with a very large tourist trade, especially amongst binge drinking young people, has the highest percentage of women at risk of harm from alcohol consumption.

This is followed by the Peninsular and the Central Health Regions which are both rural/remote and the Sunshine Coast, another tourist area. However, the Wide Bay Region which is also classified as rural, though it is in fact a fast-growing coastal urban area, has the lowest percentage at risk. Of particular interest is the fact that these patterns are not attributable solely to differences in the age-group composition of the regions.

Likewise, an analysis of liquor sales across these Health regions in 1989-90 shows that the Central West, the South West, and the Peninsular and Torres Strait Island regions (together with the South Coast region) purchase alcohol at levels considerably higher than the State and national averages (15.9, 15.6 and 15.1 litres per capita for those over 14 years of age as against 10.2 litres for the State). These regions ranked along with the three highest alcohol consuming countries in the world (Crook & Kowalski 1992, 2).

As well, Queensland Health has collected the alcohol-related hospital morbidity and mortality data for females in 1990 in the various health regions and converted it into rates per 100,000 population (Tables 1 and 2). When these are compared with the reported usage from the surveys one can see an immediate problem with the use of hospital data. Wide Bay, with the lowest percentage of women drinking at high risk levels, has in fact the highest hospital morbidity ratings per 100,000 population. Either the region is more careful to record such data accurately and others have underestimated, or people from other regions are being hospitalised in the area or the area has more hospital facilities available.

■ Northern Territory

There is also a relatively clear picture of the alcohol use of women in rural and remote areas in the Northern Territory. This is partly fortuitous - there is only one small area, Darwin, that is not officially classified as rural or remote, so State statistics are more likely to present an accurate picture of rural and remote area statistics. However, it is also true that more research has actually been done on alcohol usage amongst both males and females in the Territory. This is because the Territory has been associated for so long with heavy drinking that the two are almost synonymous (Lyon 1990, 22).

In 1992, a sample survey of Northern Territory residents in Darwin, Katherine, and Alice Springs was carried out by the Alcohol Policy Unit of the Northern Territory Department of the Chief Minister (d'Abbs 1992). It was a survey of residents in towns only - although the latter two towns are within the Remote Zone classification. It should be noted however, that the report actually claimed that remote communities were not represented. This is a typical example of people having very different notions of what is urban and what is remote - depending on whether their frame of reference is national, state or regional.

The picture of female use of alcohol that emerged was:

- that similar proportions of women drank in the week prior to interview as in the National Health Survey (57.7 per cent),
- that the mean number of drinking days for women was 2.9 and the mean consumption was 44.1 ml of alcohol in that week,
- that 4.3 per cent of the women in the sample consumed alcohol at harmful levels and 7.6 per cent at hazardous levels; of those women that drank, the percentage drinking at harmful levels was 7.4 per cent and at hazardous levels was 13.1 per cent

However, of perhaps greater interest is the statistics that emerge on the number of days of harmful drinking: among female drinkers 42.1 per cent consumed at harmful levels on 1-3 days in the week prior to interview and 6.6 per cent did so on four or more days (d'Abbs 1992, 4-5). Table 3 shows that harmful levels of drinking are twice as prevalent amongst women in the Northern Territory as in Australia as a whole. Moreover, although most male and female respondents claimed to be familiar with recommended safe drinking levels (SDL) only one in ten actually knew the SDLs for women. Moreover, women were less likely than men to be able to say what constituted a standard drink, and women under 25, over 45 years, and who were Aboriginal, were the least likely to know (d'Abbs 1992, 5-6).

The drinking pattern for Northern Territory women is that younger drinkers consume at harmful levels less frequently than older women, but consume more when they do. The frequency of harmful drinking rises with age. However, older women are still more likely overall to be responsible drinkers than younger women. Also, women with tertiary education - which is a broad indicator of higher socio-economic status - tend to drink less than those with trade or high school qualifications. This is similar to the pattern for men. What is strikingly different about the patterns of men and women in the Northern Territory is that those women who are separated, widowed or divorced (i.e. without a male partner) are much less likely to consume alcohol regularly at harmful levels than are married women. The opposite is true for men (d'Abbs 1992, 31). This may suggest that women in the Northern Territory have their drinking behaviours strongly affected by their desire to socialise with male companions or partners: that is, they have to join men in doing what they do.

Women in the Katherine sample drank significantly less than women in the Alice Springs sample. No reason was given for this but it is similar to the Queensland pattern in that general regional differences do not appear to be explainable by age differences alone.

In the Northern Territory women are more likely to buy alcohol from supermarkets or restaurants, whereas men are more likely to buy from bars, clubs and hotel/motel bottle-shops (d'Abbs 1992, 41). Moreover, many events and fund raisers get special temporary licences which encourages both men and women to buy alcohol when attending social and other special events.

The picture of Aboriginal women's use of alcohol in the Northern Territory comes mainly from the survey of Drug Use Patterns in Northern Territory Aboriginal Communities 1986-1987: by Watson, Fleming and Alexander (1988). According to this survey, a significantly higher percentage of women in town camps drink in comparison to women in other situations (Table 4).

Also, women in the Katherine and Centre Region were more likely to be drinkers than those in the Top End - at least than those in the major communities and outstations in the Top End (not in the town camps) (Table 5). The estimates by Watson et al. of the amount of alcohol consumed by women who drink indicate that 67.9 per cent drink at harmful levels and only 15 per cent at responsible levels (Table 6). This is not very different to the estimates for men (Watson et al., 1988, 12).

The Northern Territory Government looked into the measures that might reduce alcohol use and abuse in the Northern Territory (Sessional Committee on Use and Abuse of Alcohol by the Community, Report No. 2 1991). The report's overall recommendation was that the availability and marketing of alcohol be more carefully controlled and that stricter surveillance be maintained by licensers and police to prevent intoxication in public places and the selling of alcohol to underage people. It was also suggested that the number of liquor outlets in the Northern Territory be reduced because there were one-third more liquor outlets than elsewhere in Australia for the same population level. There was an even greater discrepancy when compared to Queensland and Western Australia, the other two States with northern outback areas like the Northern Territory (pp. 37-38).

Both of these recommendations have special ramifications in small communities, however. For example, with respect to the second recommendation, it was pointed out that:

> ...the size of the population in the smaller centres and their distance from each other means that licensed outlets are simply existing on less custom than in more populous areas. This could place greater pressure on some licensees to resort to less acceptable, if not illegal, means of increasing their takings.

It can and has been argued that a number of liquor outlets, particularly in the more remote areas, depend for their continuing existence on catering for people within the local community who are drinking at dangerous levels, as well as providing a service in such a way as to encourage drink driving. This also applies to some outlets in the larger centres, including Alice Springs and Darwin. If this is the basis for the economic viability of an outlet then there is no acceptable reason why it should continue to have a licence (Sessional Committee NT, 1991, 38-39).

The NT Alcohol Policy Unit collected people fs opinions of the factors that influenced drinking behaviours in the Northern Territory (Crundall 1993). This study reflects how people put reasons to why things are the way they are. In this case, both women and men believed that alcohol acted as a social lubricant, stress reliever, and thirst quencher in the hot climate. It was also seen by women to be part of the frontier image for men. Many respondents believed there was a great deal of pressure on women to match men fs drinking, although others said there was still a double standard with respect to which sex could legitimately become drunk. It was believed that women as well as men would find it very isolating not to drink, as all sporting events, informal social events and formal public events were accompanied by alcohol. Moreover, it was generally believed that heavy drinking was probably strongest in the smaller and more remote towns as well as in the Alice and wherever there was a defence base (Lyon 1990). Anglo-European women in Alice Springs believed that the ability to buy alcohol from food stores made it easier for women to purchase it without being noticed and was one of the key encouragers for them to increase their consumption when drinking at home.

The study *What everybody knows about Alice* (Lyon 1990), is a comprehensive description not only of the drinking problem in Alice Springs and its results but of the services that attempt to deal with it in both the Aboriginal and non-Aboriginal communities. The study also suggests that the drinking rate amongst Aborigines in town camps is higher than Watson fs figures quoted earlier in both the town and camps in Alice Springs and the remote communities in the Centre. The situation is very resistant to change because it is now a self-perpetuating social norm and because drinking is either considered to be pre-eminently the business of the individual (and not something upon which others have an influence), or the responsibility for causing and thus solving the problem is off-loaded onto someone else - either the Aboriginal or Anglo-European community - depending on who is talking (Lyon 1990, 43; Hume 1989, 44; Brady 1989, 23).

■ **Western Australia** (Figure 11)

The only regionally-based alcohol statistics in Western Australia appear to be the collection of hospital statistics of admissions which are wholly attributable to alcohol use from 1981-

1990 (Veroni et al., 1993). These only cover the following conditions: alcohol psychosis, dependence, abuse, polyneuropathy, cardiomyopathy, gastritis and liver disease. They do not cover secondary diagnoses attributable to alcohol or hospital admissions where the condition may be partly attributable to alcohol. The report quite tantalisingly claims that there are some quite dramatic differences in hospital rates both over time and between regions, and that these are probably the result of regional differences in socio-economic conditions, rates of workforce participation, relative levels of disposable income and other economic factors. The differences are also seen to be linked to the differences in the rates of consumption of various types of alcoholic beverages and to genetic factors (such as sex). However, it also claims that further research is required to investigate properly the reasons for the regional and time differences.

A summary of the statistics for women by region is contained in Tables 7 and 8. The most salient points to glean from these tables (and from the more detailed appendices in Veroni's report) are that there has been a significant increase in the alcohol-related hospital rates for women in the Kimberley and Pilbara Regions, that the hospital rates are highest, overall, in the remote regions of the Kimberley, the Goldfields, the Mid-West and Gascoyne and the Pilbara. It appears that higher proportions of non-Aboriginal women not Aboriginal women (per head of population ASR) are hospitalised in these areas. In fact, the highest levels of Aboriginal women hospitalised are in the predominantly 'white' rural areas of the Central Wheatbelt and the Great Southern Region. The lowest rate is in the Kimberley area and the Pilbara. Nobody knows why this is so. Veroni et al., (1993) make the point, however, that the overall hospitalisation rates for the Kimberley, Pilbara and Goldfields Regions are matched by a markedly higher per capita alcohol consumption rate in these regions when compared to the rest of Western Australia (Philp & Daly 1993).

■ Other States

Enquiries with the Health Departments in Victoria and Tasmania, showed that there were no regional statistics available that might indicate the levels of rural women's drug and alcohol use in those States. South Australia could only provide a list of clients of DASC services by drug use and area, which is considered in Section 2. However, this gives no idea at all of the usual patterns of drug and alcohol usage amongst women by region in that State.

Tobacco

The National Picture

The national picture on women and smoking is that 28.5 per cent of women currently smoke tobacco. The 20-24 age group has the highest smoking rates. Women classified socio-economically as 'lower blue collar' are twice as likely to smoke as women in other socio-economic groups. More young girls than young boys smoke regularly.

The Rural/Remote Picture

Again, it is within Health Department surveys and data collection in the various health regions that any statistics at all that might indicate the smoking habits of rural and remote area

women are to be found. Such information is available in New South Wales, Queensland and the Northern Territory.

■ New South Wales

Results from the health region surveys suggest that all the country health regions except for the New England Region have a higher rate of female smokers than the State average of 24.3 per cent (Farrell & Wraight 1993, 52). However, highly urbanised and country areas are mixed up together in their percentage of smokers. Central Sydney has the highest rate followed by the Central West, Orana Far West and the Central Coast.

■ Queensland

Again, Queensland has its mortality and morbidity statistics from all the health regions as well as the telephone surveys mentioned previously to build up a regional picture of tobacco consumption and its probable health effects. The mortality figures are age standardised but the morbidity figures are not. These figures are summarised in Tables 9 and 10. The mortality rates in Table 9 have been calculated by multiplying the mortality data from the registers of deaths in 1988 for each region by the aetiological fraction used for tobacco. The morbidity data in Table 10 are based on the number of individuals leaving hospital having been diagnosed in 1988 with tobacco-related disorders plus an aetiological fraction used for tobacco-related disorders. Results from Tables 9 and 10 suggest that although there seemed to be higher than expected rates of hospitalised illness due to tobacco smoking in the remote areas of the South West and Central West, the mortality rates were highest per head of population for the coastal regions where the elderly retire, i.e. the Sunshine Coast and Wide Bay, and the working class area of Brisbane North. In both cases, the South West appeared to have higher rates than expected. This may possibly be the result of the small sample sizes or the tobacco growing industry in parts of the region.

When using the telephone survey data on tobacco consumption, it should be noted that the sample sizes for females in each of the age ranges (Table 11) are in fact quite small, so that there are fairly wide confidence ranges for the figures. Also, Queensland Health statisticians have warned that the survey probably under-represented the unemployed who are more inclined to smoke. Therefore the figures may under-represent the extent of smoking.

Interpreting these consumption rates at face value, it would appear that the rural and remote regions in Queensland tend to have lower rates of females in the 18 to 30 cohort smoking than the metropolitan areas which runs counter to the situation in New South Wales. Again, in the 31 to 50 age cohort, the rural and remote areas of Queensland appear to have lower levels of smoking than the metropolitan areas. In the over 50s cohort, however, the situation is reversed. Here the Central, South West, Central West and Northern Regions have significantly higher levels of smoking than the metropolitan areas. However, there are also rural regions that have rates lower than the State average (Wide Bay and Mackay).

Overall, the statistics from Queensland reveal that there is probably a great deal of variation in the smoking levels in different regions for the same age cohort of women. This may be reflecting local variables such as tobacco growing (in the South West) and conservative religious populations (Wide Bay).

■ The Northern Territory

There are survey statistics for the prevalence of tobacco smoking and chewing amongst Aboriginal women in 1987 but not for non-Aboriginal women. Table 12 shows that three-quarters of the Aboriginal women surveyed in the Top End smoked but only one-third of women in the Katherine Region and under ten per cent in the Centre. Instead, women in these latter regions tended to chew tobacco. There was little difference in the smoking rates across the age groups in the Top End, but it tended to be higher in the younger age groups in the Katherine and Centre Regions. The older women preferred to chew tobacco (Table 13).

Other Drugs

There are almost no statistics or surveys that give us a picture of rural and remote women FS use of other drugs. The only data located comes from the NSW Health Region surveys and surveys of Aboriginal communities in the Northern Territory on the prevalence of analgesic use and the South Australian statistics on DASC clients.

Table 14 summarises the results of the NSW Health Region surveys on the use of pain relieving drugs. Their use appears to be lower in rural and remote areas than in metropolitan areas. However, the statistics do not take account of the age profile of the region, so it is not possible to tell whether these statistics simply reflect age rather than locational variables.

It seems, on the surface, that the Northern Territory Aboriginal communities have a high percentage of women taking analgesics, a percentage which is fairly constant across regions (Table 15) and across age groups (Table 16). However, this is does not measure the number who have taken them in the two weeks prior to interview as does the NSW statistics. Rather, it measures who tends to take them when they need/want to do so. It does not indicate, therefore, the amount of use.

The 1993-94 statistics on rural/remote women in South Australia using DASC treatment services (Table 17) shows a poor use of services for the prescribed drugs and a high percentage of clients actually presenting for methadone treatment.

Western Australia collected hospital statistics on petrol sniffing between 1981-86 because of a concern about the prevalence of petrol sniffing by Aboriginal children in the Western Desert Region in 1987. It had been reported by Smith and McCulloch that about 90 children in this region were practising petrol sniffers in 1986 but that only eighteen of these were identified as chronic sniffers. Hayward and Kickett's report, which analyses the morbidity and mortality figures on the problem, highlights the great difficulty involved in getting an accurate picture both of the extent of the medical consequences of such practices as well as of its occurrence.

Not only is the problem connected with getting accurate information in the form needed by researchers from remote Aboriginal communities, but it is also connected with getting enough information from the ABS system of coding where only single causes of death are recorded. As with all drug taking, the medical system can hide the effects of drug use by using terms which refer to the immediate process by which a person died rather than what practices encouraged that process to happen (for example, asphyxiation rather than petrol sniffing). However, even given this caveat, it would appear from the report that whereas those

presenting to hospitals with medical problems arising from petrol sniffing in the early 1980s tended to be metropolitan males and females over the age of 25 (with slightly more females than males), by 1986 it had become a problem of predominantly younger Aboriginal males from remote areas. However, the number of Aboriginal females involved was also increasing. The numbers of non-Aboriginal males and females remained constant.

In the study of drug use in NT Aboriginal communities by Watson et al. (1988, 8-21 and 40-43), the extent of the use of kava was investigated. It would appear that in 1987 kava drinking was primarily confined to six Arnhem Land communities. There was considerable variation between the communities in the number of women who drank kava. This depended on how it was introduced to the community and what meanings attached to it. Where it was introduced by prominent community members who had travelled to Fiji and then used it as a communal activity, about half the women drank kava.

Summary

The most information about rural and remote women's drug use is available on their use of alcohol, and it would seem that use varies according to location and not just according to age. It is in the areas that are very popular with tourists and transient young people or single young males as well as in the remote areas - especially in the North - that women are more likely to have high levels of alcohol usage. This appears to be irrespective of whether there is a high disposable income or chronic disadvantage, so long as it is combined with a drinking culture. It would appear that women are being more influenced by and therefore adopting the traditional drinking attitudes and practices of men. These attitudes are being supported to some extent by modern leisure-linked promotions of alcohol usage for both men and women. Remote and rural women are likely to drink a lot more full-strength beer than in urban areas and less wine.

With regards to the use of tobacco, the picture is confusing. It is possible that rural, and especially remote area women in particular regions tend to smoke more than metropolitan women. But it is in the more highly urbanised areas that the morbidity and mortality figures are highest - perhaps reflecting the movement of the elderly population out of the remote areas or the tendency for people to go to hospital in these areas.

The only time the other drug using habits of rural or remote area women are investigated is when there is strong concern over a particular problem voiced by regional health or community workers to the central policy makers within the State health department. However, as the Western Australian petrol sniffing issue suggests such data tends to be collected because males are also involved, as this is more threatening to the stability of the community.

III RURAL SOCIOLOGY AND WOMEN'S LIVES

There is a whole tradition of rural community studies replete with theories about the differences in the structure and social interaction patterns of small and large communities. For those who wish to take a properly holistic - or ecological - view of rural women's lives

when they look at their drug and alcohol use, it is imperative that an understanding of the structure and processes of their communities as well as of the day-to-day content of their lives be understood. One should understand how the social processes in small communities differ from those in large urban agglomerations, starting, perhaps, with Kenneth Wilkinson's work on the community in rural America (1991) and Granovetter's thesis on the importance of weak ties. Both make it clear that small, dense, strong-tie communities are self-reinforcing and hard to change from within. They need new influences and weak ties with people on the outside. Wilkinson also challenges the tendency to romanticise smaller communities that is contained in the currently fashionable belief that it is intrinsically bad for service providers, policy makers and community development workers to disturb and weaken the cohesiveness of such communities and to break down their cultural values - whatever these happen to be.

Also important is Martinez-Brawley's work (1982, 1990) on the structural factors affecting small rural communities, and on social network analysis and their implications for social work in such communities. Her work fosters an understanding of how to adapt one's professional practice and service delivery policies to rural needs and conditions. Taking such a broad ecological approach is particularly important because social networks and the range of opportunities available and the direction and speed of change are so important to rural and remote women's lives. It has been said, for example, that the presence of strong emotional ties and of practical help with child-rearing tasks are very important to the quality of life and the mental health of women. Strong ties and the high density networks which provide these in the absence of formal services often characterise traditional communities. Yet there is also some social network research which suggests that when women need to significantly change their identity by taking up lifestyles and activities that are non-traditional they need low density (i.e. weak) ties which are not based on their traditional family roles (Hirsch 1984). These are far less likely to be available to women in smaller rural and remote communities. This has implications for the way services are provided for drug and alcohol abusers. After all, the pressures to conform to accepted practice and the narrow range of perspectives that often prevails in small communities are keyfactors in dense networks.

It would be vital to consider at least one of the detailed community studies that have been carried out in rural Australia. The most significant is Ken Dempsey's study of a small traditional agricultural community in Victoria which he names Smalltown (1991). In this study he explains how rural people construct their identity and how structural inequality, marginalisation, exclusion, and belonging happen in such communities. He delineates the choices and constraints faced by rural townspeople, as they see them. Dempsey summarises the overall character of life for many people in similar towns (which, by the way, is in the Rural Other classification) in the following way:

> "It is not ruralness as such but the community's small and stable population, its geographical isolation, the presence of the institutions in which individuals participate on a day-to-day basis, and the multi-stranded ties the latter help to produce, that have a crucial bearing on the character of relationships. ...people are friendly and demonstrate care provided, of course, one conforms... ...classes and gender constrain and channel informal and formal activities and the occurrence of expressive and caring relationships... But the palpable attachment to the place and its people of individuals of all ages, both sexes and of all classes cannot be dismissed as an example of false consciousness or merely the product of manipulative activities... the subjective

> attachment is born, to some extent, of objective realities: ties and activities that, at time, transcend classes, gender and age divisions; and economic and career realities that go some way towards creating a common fate for Smalltownites generally...
>
> ...While some who do occupy a disadvantaged position in the local system would leave if they could, many would not leave. This is not only because they may be better off economically in this community but because for these people it is an entity associated with the intimate areas of their lives and the fulfilment of fundamental human needs... More specifically, Smalltown is associated for them with the powerful sentiments generated by ties of kinship and friendship and by the experience of being known and accepted, even if it is only by members of one's immediate circle. The sense of belonging and attachment these produce diffuses to the community generally . ...it persists in the face of significant class -, age - and gender based systems of superordination and subordination. It seems most people need to have a sense of belonging somewhere (Dempsey 1991:121-124).

This need to belong to a place and conform to a social group is the first major factor that needs to be considered when tackling women's drug and alcohol problems: which women will come for help to the local community health service where they will have to reveal a problem to people they may meet in other contexts? Will they take up residence out of town?

Dempsey also talks about those negative qualities of small town rural living which urban professionals often find so hard to cope with: the very strong requirement that people conform to the dominant values and lifestyle of the group to which they naturally belong; the scape-goating of newcomers; the limited range of life options and social and cultural contacts, especially for women; the them-and-us mentality towards large administrative units and city life generally; the interest in people's personal lives (gossip); the conservative understandings of men's and women's roles and of other social issues; and the relatively greater valuing of personal contact and personal attributes in public life and formal service provision than in city areas. The likely implications for drug and alcohol needs identification and programs in such communities are superbly illustrated in the difficulties faced by the COMPARI program in getting established in Geraldton, Western Australia (James et al. 1993).

Dempsey's picture of the conservative nature of Smalltown values and attitudes is reinforced by Kelly's analysis of rural responses to the Family Formation Project in the early 1980s. Kelly summarised the demographic picture of traditional towns in the 'Rural Other' category as one of:

> "...lower education, employment and income-earning opportunities and earlier ...partnering and parenting, in an environment which is relatively homogeneous with respect to the ethnicity, religiosity and socio-economic status of the citizens (Kelly, undated, p.10)"

These factors and the size of the community predicted conservative views of men's and women's roles and behaviour - at least with regard to their family responsibilities, views of marriage etc.

There are also two feminist analyses of women's lives in traditional rural areas: Poiner's study of Marulan (1990) - which is now rather old as the research was done in the late 1970s - and Dempsey's work based on the Smalltown study entitled A Man's Town: Inequality Between Women and Men in Rural Australia (1992).

Dempsey makes the overall point that although there are signs of change, women in small agricultural towns in the late 1980s are still largely excluded from formal public offices and from much of the public social life and business of the town. The belief is still strong amongst men that men are better fitted, by temperament and experience, to take the big decisions. Moreover, their emotional experience tells them that they cannot comfortably be themselves and relate to each other in the ways they know well when there are women around. Women are still expected to be good wives and mothers and to support and work for their husband's and son's clubs and leisure activities.

In Dempsey's study, many of the Smalltown women complained about not having enough time and attention from the men. If they wanted to relate more to men they had to join them in their interests and take up whatever auxiliary roles were allowed to them because men did not join them in women's interests. Dempsey observes that in the late 1980s women were being accepted doing non-traditional things in Smalltown as long as these did not interfere with a woman's primary duty to be a good wife and mother.

Of particular interest to the subject of this paper is the place he gives to drinking in the segregation of the sexes. He and his informants paint a picture of small town pubs in the traditional agricultural areas full of men at the bars drinking together, doing business and socialising, and of (supposedly mixed) social occasions which observe an unwritten rule of segregating the men and women - the men drinking beer around the keg or bar and the women drinking wine or non-alcoholic beverages in the lounge or main area where the occasion is held. Dempsey reports that he was told repeatedly by women of the town (who often 'would not be caught dead' in the bars of the local pubs):

> "Of course this is a man's town; have you ever seen so many pubs in such a small place? They've got their mates to drink with ...any man will always find someone in the bar he knows to drink with even if he goes to the pub by himself. (Dempsey,1992:48)."

Dempsey points out that local, non-professional small town women only started entering the public bars of the town's seven hotels in the mid-1980s. However, in the 1980s it was common practice for young women to drink quietly in the lounge whilst their boyfriends drank and talked in the nearby bar for as long as they chose to do so. The popularity of hotels for young females as well as males was understandable because there were no other gathering places for adolescents. Moreover, teenage culture, carried to the towns by the media, promoted it as desirable. However, husbands stated that if necessary they would forbid their wives to go to the hotel bars (p.57). Married women were bound still in these more stable communities by a code of respectability for wives and mothers even into the 1990s. Although there are signs of women going into the bars of rural pubs in the 1990s, drinking is still largely segregated.

A more complete explanation of this male/female relating around alcohol is suggested by Campbell and Fairweather's work (1991). Although the observations on everyday public drinking belong to rural New Zealand, I believe they accurately describe what happens in rural Australia as well and give a more complete context to women's use of and attitudes towards alcohol. Campbell and Fairweather state that the drinking ideology prevalent in rural communities is that it promotes an integrated, friendly, well functioning rural community. However, this is only based on men being together and it is actually hostile to women's and children's legitimate calls on men ╒s attention and commitment. Rural pub atmospheres are aggressive towards women, always symbolically and sometimes actually. It is unmasculine to exhibit signs of commitment to female partners or children. They use derogatory humour on men going home from the pub too early or going with women who make a claim on their attention. Sexual behaviour which is considered appropriate for a single male is the preferred ideal for even married men. Women, therefore, have the choice of joining the men (inasmuch as they are permitted to do so), drinking with them and competing with their mate ╒s male friends for attention, or staying at home, or joining other women in their own separate socialising rituals. One of the socialising rituals that has already received some attention is that of playing darts at ladies nights at the pub or club (Hunt & Satterlee 1987).

Some work has also been done on the lives of women in Australian mining towns. Claire Williams (1981) has detailed from a Marxist feminist perspective, the lives of the working class in the Queensland coal-mining town of Moranbah. Moreover, work was done over many years by Cecily Neil and colleagues in the CSIRO's Remote Communities Research Unit (now defunct) on the lives and mental health of women as well as men in the new remote mining towns of Western Australia. Such work is summarised in my report on Women and Services in Remote, Company Dominated Mining Towns (Sturmey 1989). The main points that emerge for women in mining towns are that they and their partners generally have very high disposable incomes, that the women are cut off from their emotional ties with family and long-standing friends, that they have city habits and expectations, that they are in the child-rearing stage of life and that they can be lonely and bored if they are not keen on sport, do not have well-developed social skills, and are not used to taking initiatives in establishing new relationships and interests. Moving to a remote mining town can be a big challenge to their personal coping mechanisms. Even more so than in rural areas, the culture of mining towns is formed around the culture of single young males.

Women in the remoter mining towns have a particularly difficult time if there are problems in their relationships with the nuclear family members that are there with them. Being 'locked into' emotionally difficult situations with no chance to share them with informal social supports or formal services (both of which are more scarce and there is less choice) and with the need to keep up an acceptable image for their new social contacts in the town, appears to be more than a significant number of women can cope with. Anecdotal evidence suggests that many mining town women turn to alcohol or prescribed drugs to deal with the stress. The use of alcohol is made so much easier by the drinking culture that engulfs them. However, of more significance perhaps, is not the use of alcohol per se to cope with personal problems but rather the way women, too, in the mining towns are increasingly structuring their own social activities both with each other at home or on girls nights out or with their partners and with other couples around alcohol. The drinking culture that surrounds them makes it easier to change their own attitudes to the role of alcohol in their lives. My experience in mining towns in the 1990s indicates that women are also drinking heavily.

IV RURAL AND REMOTE AREA SERVICE PROVISION

Little systematic work has been done on models of service provision in non-metropolitan areas. The most comprehensive listing of models has been done so far by Barry Smith who presently represents rural and remote service delivery interests within the Strategic Policy Section of the Federal Department of Human Services and Health (see Smith 1987, 1989).

Also, at the present time, Kerry Brettall of Centacare, Wagga Wagga, is working on a thesis that will update and expand Smith's work. This should soon be available through Charles Sturt University, Wagga Wagga.

The present conditions that are shaping rural and remote area service delivery for some State Government departments and non-government organisations are neatly summarised in the Victorian report Study of Government Service Delivery to Rural Communities (Office of Rural Affairs 1991). This report presents an excellent picture of the trends in service provision in Victoria, NSW and South Australia - the main States concerned with cutting costs in human service delivery (pp 105-106). Meanwhile, Queensland is in a period of expanding its human services and has other concerns besides that of cost-cutting. Here the ideals of accessibility of services and regional development are competing more successfully with cost-cutting practices.

Nevertheless, since the national Think Tank on Research Needs in Rural and Remote Service Provision in 1989 (Sturmey 1989), the Federal Department of Human Services and Health and various State government departments have had the issue of servicing the rural and remote areas more firmly on their agenda. This has allowed more money and interest to be directed into investigating the problems associated with servicing such areas. Out of this activity have come a plethora of reports on service difficulties and how to overcome them (see Bibliography). A summary of the various suggestions for adapting services in order to make them more easily accessible, cost-effective and acceptable to rural and remote communities looks something like this:

- It appears to be necessary either to have more multi-skilled generalist workers scattered amongst the smaller and more remote communities or to send specialist workers out from a large regional centre at regular intervals to service the smaller towns.

- Services which rely on professional in-put for quality need to have a strong team of experienced workers and resources either based at a regional centre or visiting the regional centre regularly or in contact via an interactive medium.

- Where services are implicated in changing attitudes in the community or in dealing with stigmatising problems, the workers either need to come in from the outside and be able to be accessed with some degree of anonymity, or to have strong support from a team of people within the community's elite which is committed to such changes.

- The personal as well as the professional qualities of workers become very important in ensuring the acceptability of the service. Workers need to understand the stages

that they might experience in coming to terms with their job and their identity in the town and how to manage these creatively (Sturmey 1992, 59-93).

- Where services need to be accessed frequently by users they must be provided in such a way that they do not require the service user to meet the high costs of overcoming distance through private transport or air travel. Otherwise, services will not in fact be accessible to many. People in rural and remote areas tend to be poorer than in urban metropolitan areas. Women and the elderly can be greatly disadvantaged by not having access to private transport.

- Well-publicised 008 telephone services with a person at the end of the telephone to provide information and counselling and support to isolated women appears to work well to fill in the gaps when service providers are not on hand.

- An increasingly popular way of saving costs on rural and remote area service provision is to share physical and perhaps administrative resources by setting up multifunctional centres or services in the smaller rural and remote communities. Often this is in a community health centre. Sometimes it is a HACC centre or family services centre.

- Community consultations and support of community committees by government workers are considered essential to the successful establishment of formal services in rural and remote communities. However, the belief that rural communities invariably have a tradition of strong community involvement by its members is being challenged. Community committee members are beginning to protest about being expected to provide the management of so many community services (Sturmey 1994, 57-95) as the government devolves service delivery to the non-government and community sector. However, it remains true that less traditional services (such as sexual assault and family counselling) can more quickly be accepted if respected community leaders are involved.

- It is generally believed that in small rural communities support groups set up to address stigmatising problems, especially if they require the public sharing of private activities and family life do not work well. However, some workers dispute this, claiming that such groups can work as long as they are developed through personal recommendation over time and that the worker does not expect to be able to bring together people who would not normally mix in the town.

- Experiences from the old Community Youth Support Scheme in rural areas suggest that services need to be based on one sex or the other, or one ethnic group or another in rural/remote areas. It is very difficult to get the people of the other sex or other race to use services that already have a certain clientele (The Rural Development Centre 1986).

- Rural and remote area people - whether they are locals or have come from the city tend to believe that they should not have to pay for health and welfare services. Moreover, as the economic resources available to the whole community are often less than those available to the population in a metropolitan area and the income of

male-headed households is substantially less, rural residents are less able to pay any costs involved in accessing services.

- It is generally believed that services which are non-traditional need a great deal of time to win acceptance. This means long time lines need to be considered in putting such services in place and properly evaluating them. It also means very active community education is a vital part of the service's role.

- A model which has been considered often and has been implemented by DSS in particular, is that of making a local service an 'agency' or contract provider of another service. Then government departments do not have to go the expense of providing their own worker and facilities (Working Party on Co-ordination 1986). However, it is generally seen to be suitable only for services that do not require highly skilled interventions.

- Although the model of a mobile service has often been held up as the proper way to go because it allows expertise to come to the service users, it has only rarely been used. Truly mobile services such as the remote area children's and family services and the flying doctor service (RFDS) are either very expensive to operate or require a missionary-like devotion to the clientele and disregard for modern notions of decent working conditions from the travelling workers. Lower status women workers (or adventurous doctors from overseas in the case of RFDS) are generally the only ones interested.

- One of the greatest problems faced when tertiary educated professionals are placed in rural or remote areas is that they require good access to supervision and professional or peer support and training, otherwise they soon leave their job. Therefore, small services seem to need a large stable organisation or plenty of additional money to provide support and resources to the workers.

- Although multi-skilled generalist workers are usually considered to be the cheapest (and by some the most culturally appropriate) response to the problem of providing a range of services on the spot to small scattered groups of people, there are serious problems being revealed with this solution (James et al. 1993; Sturmey 1992; Bush & Williams 1988). This will be illustrated with regard to generalist health workers and drug and alcohol workers in rural areas in the following section.

V DRUG AND ALCOHOL WORKERS IN RURAL/REMOTE AREAS

Bush and Williams (1988) made the point that drug and alcohol problems are more likely to come to the attention of generalist health and welfare workers as they address other problems with their clients rather than to the attention of a designated drug and alcohol worker. They point out that professionals and policy makers therefore tend to see the answer to all rural service problems as being a local team of generalist workers who are committed to dealing with alcohol-related problems on top of their present responsibilities. However, generalist workers in rural communities are often overworked with their normal responsibilities. They also have many calls to do other things as well and are either unwilling or incapable of

properly addressing this issue. Bush and Williams (1988) also established that rural health generalists are less likely than urban health generalists to give adequate therapeutic responses to alcohol-related problems because the three important predictors of such responses, namely experience with problem drinkers, training in both alcohol studies and counselling, and the immediate availability of professional support for their interventionist role are not sufficiently present to rural generalists. They make the point that generalist workers protect their self-esteem (and, it might be argued, act pragmatically and ethically) by not getting involved in addiction problems which are perceived to be intractable and beyond their competence. If there are no specialists to refer on to, nothing is done to directly address these intractable problems.

A report by James, Reilly and Krivanek (1993,1-2), on the training needs of rural-based drug and alcohol health professionals drew attention to the difficulties that such workers have in accessing appropriate training and to the fact that the services provided by many rural-based drug and alcohol workers have been shown to be unsatisfactory. The authors concluded that the greatest need of community-based drug and alcohol staff in the North Coast Health Region of NSW was for clinical supervision of their work. The second need was for more knowledge of drug and alcohol effects and treatment and the third was for assistance with their own ability to evaluate clients. The specialist methadone staff expressed a need for greater skills in crisis intervention and counselling and, again, for clinical supervision. There was no mention of the need to understand better the special concerns of women.

Overall, the need for improvement in drug and alcohol workers' skills in working with clients directly means that training has to be delivered face-to-face to workers. This means that the necessary expertise needs to be provided by State Health Departments within regions. Training needs to be provided over an extended period of time through experiential learning (as for counsellors) so that managing complex intervention processes and using the necessary interpersonal skills becomes a more integral part of the worker. This is perhaps better served by good clinical supervision and longer skills training courses rather than by short, unconnected courses (see also, Sturmey 1992, 53). However, it was also apparent that drug and alcohol workers did not always trust that present supervisors would support and encourage their learning, or that they had the skills to support them properly. Anecdotal evidence also suggests, however, that lone workers can be ambivalent about active supervision. Some that remain in isolated and unattractive service settings appear to do so because they prefer to work in ways or to standards that are not considered acceptable or because they do not like being answerable to others.

A thorough discussion of the necessary competencies of professionals in rural and remote areas and the very complex issues involved in the use of 'multi-skilled' generalist workers is provided in my earlier reports, The Survival Skills Training Needs and Recommendations Study (1991) and the Educating Social, Welfare and Community Development Workers for Rural/Remote Areas (1992), to which I refer anyone who is interested.

VI TACKLING RURAL/REMOTE WOMEN'S DRUG AND ALCOHOL PROBLEMS: WHERE TO IN SERVICES, POLICY AND RESEARCH

I wish to make the point here that as I am not an expert in drug and alcohol issues I do not intend to judge between the approaches specific to drug and alcohol treatment which should be taken on ideological grounds to the servicing of women with these problems. My comments come from my knowledge of the rural and remote area context only. Whether the reader is committed to separatist or mixed services, harm minimisation or complete abstinence, the observations I will make can still be applied.

Policy and Service Recommendations

Any policy and service initiatives in rural and remote areas need to keep in mind the following:

a). Rural and remote area services already suffer from the fact that the service delivery and support network gets thinner as the distance from the major centres of population increases. When all government departments cut their service delivery and worker resourcing and support programs in an attempt to save money the network of health professionals gets dangerously thin, even at regional centres. Moving to a system of training other health workers exacerbates this tendency.

b). Several other human service programs (for example, HACC, Domestic Violence, Sexual Assault) have already decided to use the resources of community members and other professional health and welfare workers to organise a generalist and community response to special issues and special service needs. This cannot go on indefinitely because rural and remote communities are often (though not always) the most resource-poor in terms of professional resources, materials and money. Certainly traditional medical personnel are the most likely to pick up the problems and authoritatively suggest treatment. But this does not mean they are the logical ones to use for drug and alcohol work. Attempts to use nurses, social workers, and medical practitioners should proceed only if a special program of screening, training, licensing and compulsory supervision for such workers is instituted at the same time. It is not a cheap alternative and should not be used where the service delivery network is already sparse and over-burdened and the local workers are not personally suitable.

c). Preventative education re women's alcohol abuse is better done together with the issue of men's alcohol use, because women's use appears to be increasingly influenced by men's use.

d). It needs to be remembered that effective changes to the community culture which might be unpopular can rarely be done by lone workers who have to socialise in the same community in which they work. Rural/remote community leadership tends to locate problems in which they are implicated outside the community or within a defined part of the community or to refuse to define them as problems. A great deal of outside influence is needed to balance or overthrow the influence of community leaders when they tacitly keep in place the structures and attitudes that encourage the

harmful behaviour. To some extent effective work on women's alcohol and prescribed drug taking behaviours will involve tackling influential men in the community. This is extremely difficult for women workers, many of whom are either not zealous enough about their commitment to women or cultural change to willingly endure ostracism, or not sure how to go about the process of promoting such changes even if they were.

e). Accessible and well planned worker training programs, clinical supervision and resource support together with a regionally based residential program for women is essential to quality services in rural and remote areas.

f). Generalist workers that are expected to deal with not only a range of problems but with mild to severe expressions of those problems need more advanced skills not less advanced skills than the medium range specialist. Their jobs, therefore, need to be graded as senior positions with more rather than less stringent qualifications and experience criteria to match the level of autonomous functioning that the position requires.

g). Any non-recurrent monies available to tackle the problem of rural women fs drug and alcohol services and community education is best spent in funding radical, innovative pilot programs of at least three years' duration as it takes time for services to be accepted. Practitioners with an excellent reputation in successfully assisting clients in a rural service should be encouraged to develop these. This should include an opportunity to experiment with changing the behaviour patterns and cultural expectations of the community as a whole rather than through just working with individuals. The community approach may be the best way of dealing with drug and alcohol problems within strong-tie communities as the individual is not then unnecessarily set against the pressure(s) of a relatively close-knit, homogeneous social network.

h). Demographic trends in rural and remote areas are likely to bring certain drug and alcohol patterns into greater prominence and to dilute others. As these demographic trends are now well known (Salt 1992), services and community education programs should be planned to meet these trends.

i). National drug and alcohol campaigns need to use rural themes and popular female and male personalities on regional television and radio. Alcohol-free public, sporting and fundraising activities need to be encouraged within rural/remote communities with offers of promotional support and a cessation of the practice of granting temporary licences for such events.

j). Priority probably needs to be given to tackling the issue of alcohol abuse in remote communities amongst both Aboriginal and non-Aboriginal people and those coastal areas with high proportions of transient young people and industries based on leisure.

k). There is little point in training rural general practitioners not to prescribe minor tranquillisers unless they are taught other ways of handling such patients, or rural

women are taught to manage and be comfortable with their emotional reactions, or professional counsellors are more readily available in rural and remote areas.

l). There is always a tension between providing services in the smaller communities to increase accessibility for women and in a large regional centre to maintain anonymity.

Research Recommendations

a). As drug and alcohol usage patterns may vary markedly depending on the characteristics of the rural or remote area community, a national research project that examines, via extensive surveys, the drug and alcohol profile of women in a representative range of community types and then updates it every five years would provide valuable information on the effects of cultural and demographic changes, changes in supply and the effects of national and local campaigns on drug and alcohol use and treatment in different types of rural and remote communities. The material would also be excellent source material for rural and remote area drug and alcohol workers.

b). An intensive in-depth study of women's drinking and drug use and culture be carried out in a traditional country town and a mining town using new paradigm research methods (Astbury et al. 1991). Particular attention needs to be given to discovering the links to the male drinking culture, the local definition of acceptable and unacceptable use, how women move from social use to dysfunctional or addictive use, the extent to which the town's culture supports and encourages harmful use, etc. The study would need to look always at the male-female dynamic and therefore cannot be focused on women separate from men. Moreover, the study should consider the changing of women's behaviour in the light of the sociological literature on how change is promoted and resisted by small communities and by male partners.

I do not recommend that research money be spent in reviewing service delivery issues. Enough work has been done to allow their application to drug and alcohol services provided that the following parameters are taken into consideration:

- the frequency, skill and intensity of service delivery that is needed for successful outcomes for the interventions needed for drug and alcohol work;
- the stigma attached to the presenting problem for rural/remote women, and the need for revealing personal information that is part of the management/treatment process (if both are high then workers should probably not be based in the towns they service);
- the density of the whole health services network in that particular region; and
- key characteristics of the women needing to be serviced.

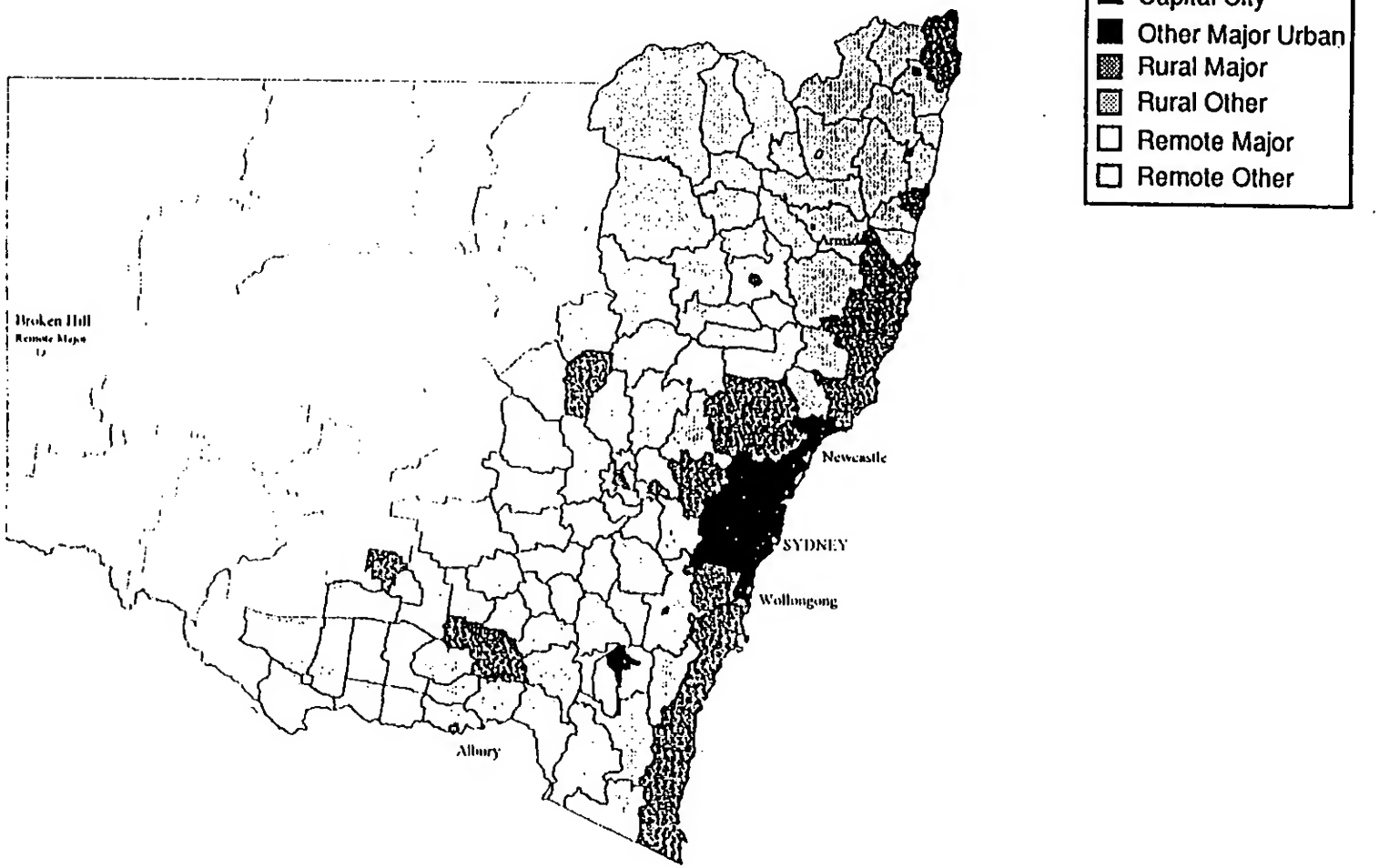

Figure 1. Rural and Remote Areas Classification, New South Wales
(Source: 1991 Census, produced by Statistical Services Section 1993)

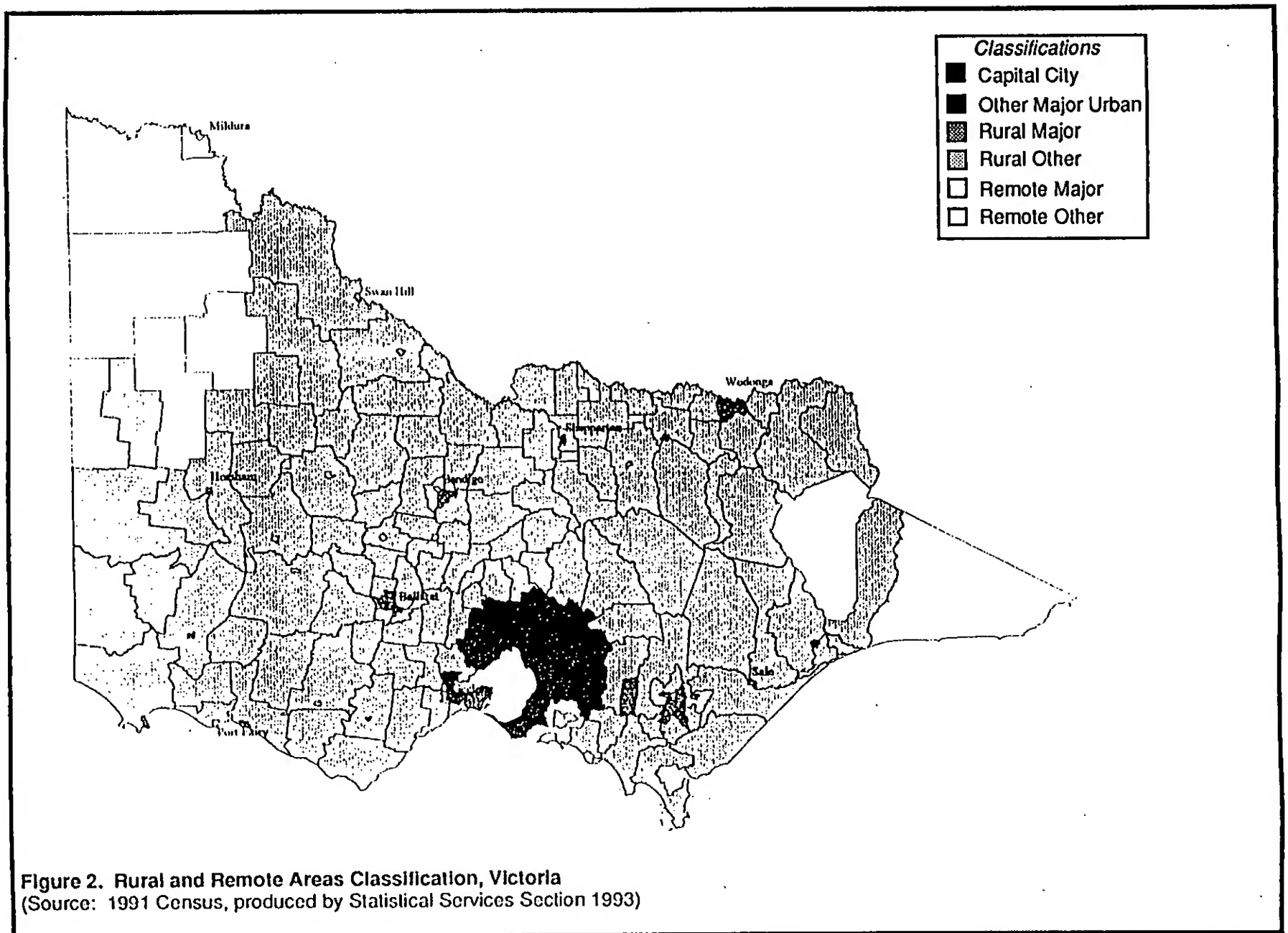

Figure 2. Rural and Remote Areas Classification, Victoria
(Source: 1991 Census, produced by Statistical Services Section 1993)

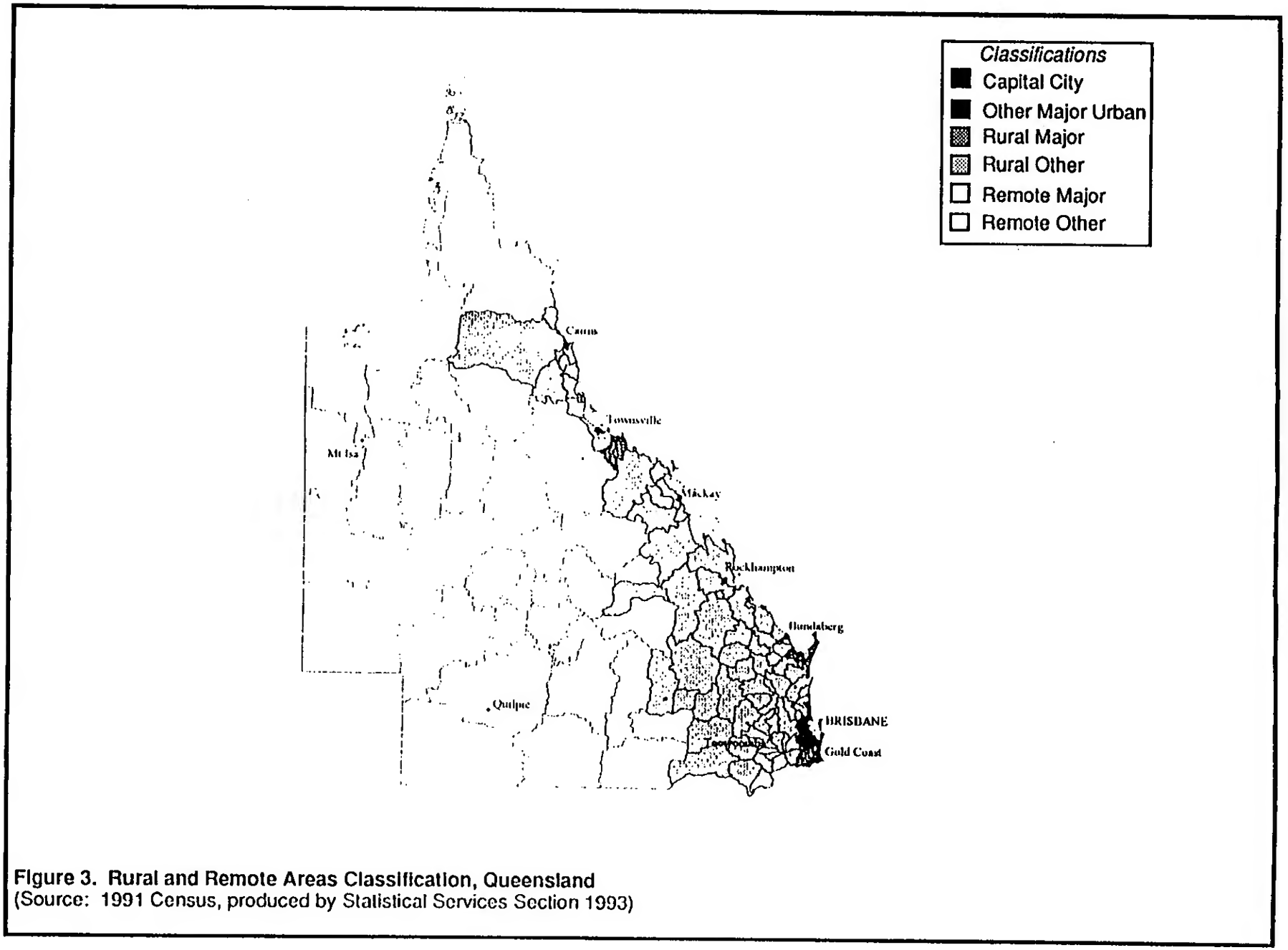

Figure 3. Rural and Remote Areas Classification, Queensland
(Source: 1991 Census, produced by Statistical Services Section 1993)

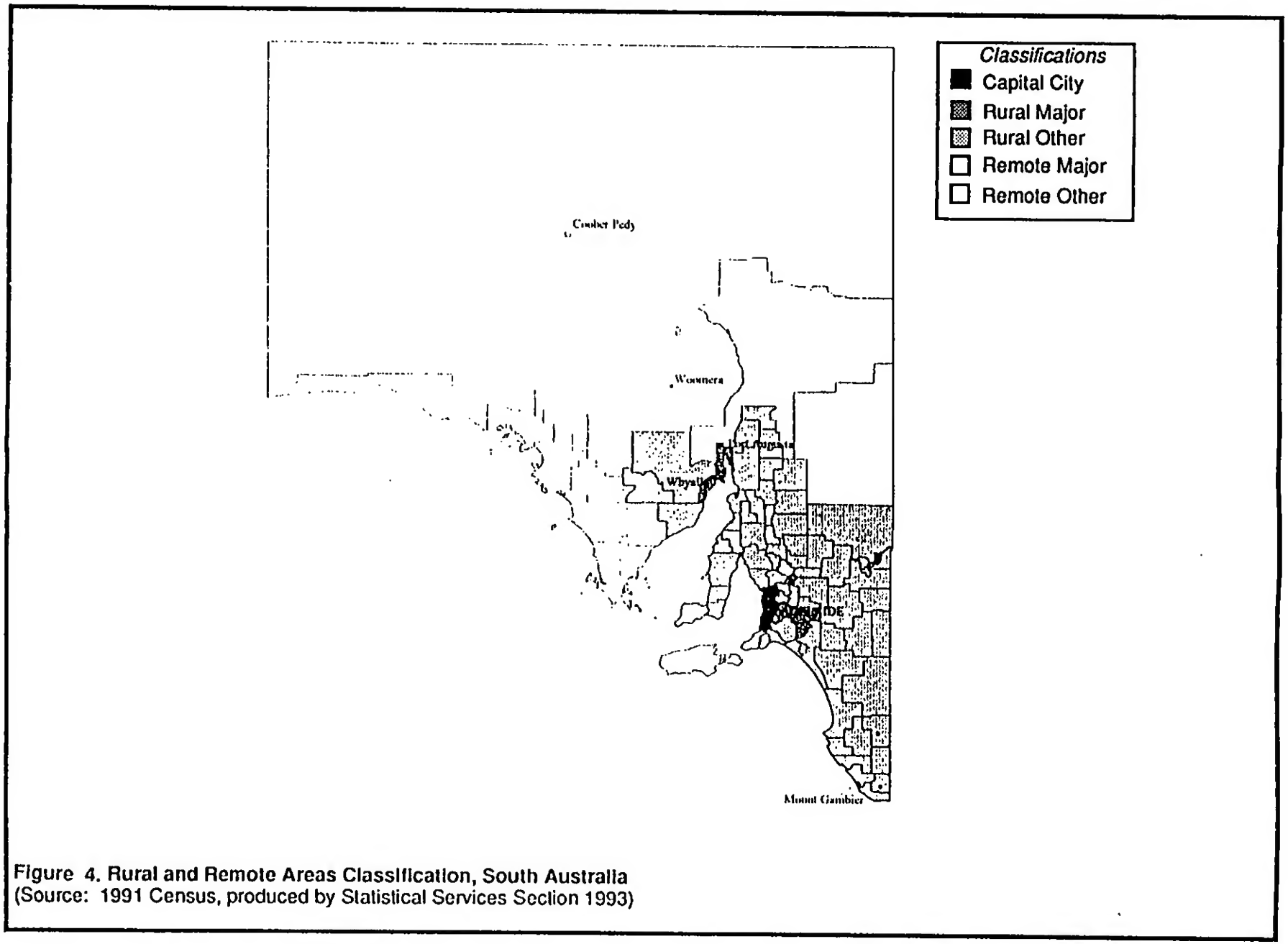

Figure 4. Rural and Remote Areas Classification, South Australia
(Source: 1991 Census, produced by Statistical Services Section 1993)

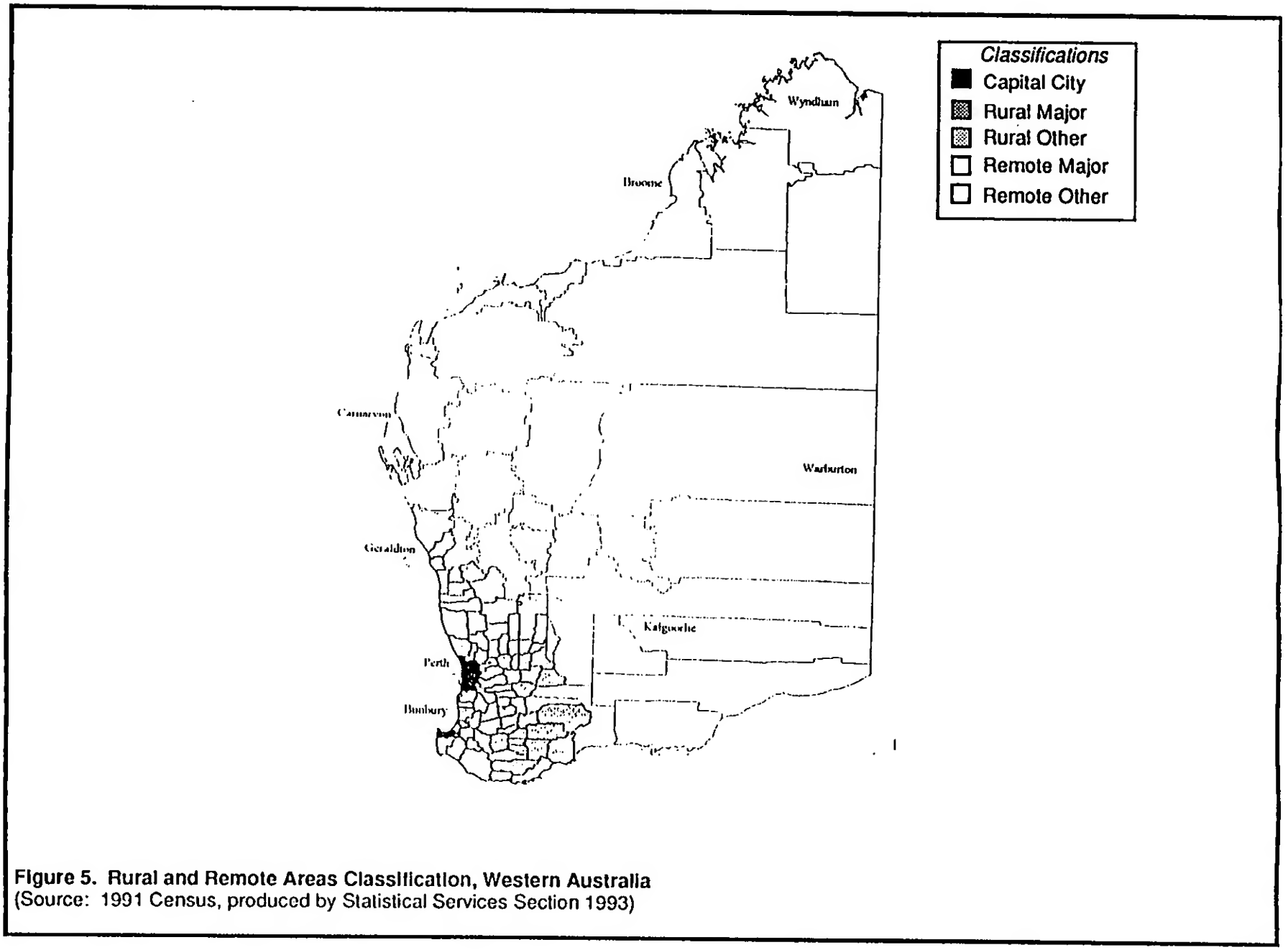

Figure 5. Rural and Remote Areas Classification, Western Australia
(Source: 1991 Census, produced by Statistical Services Section 1993)

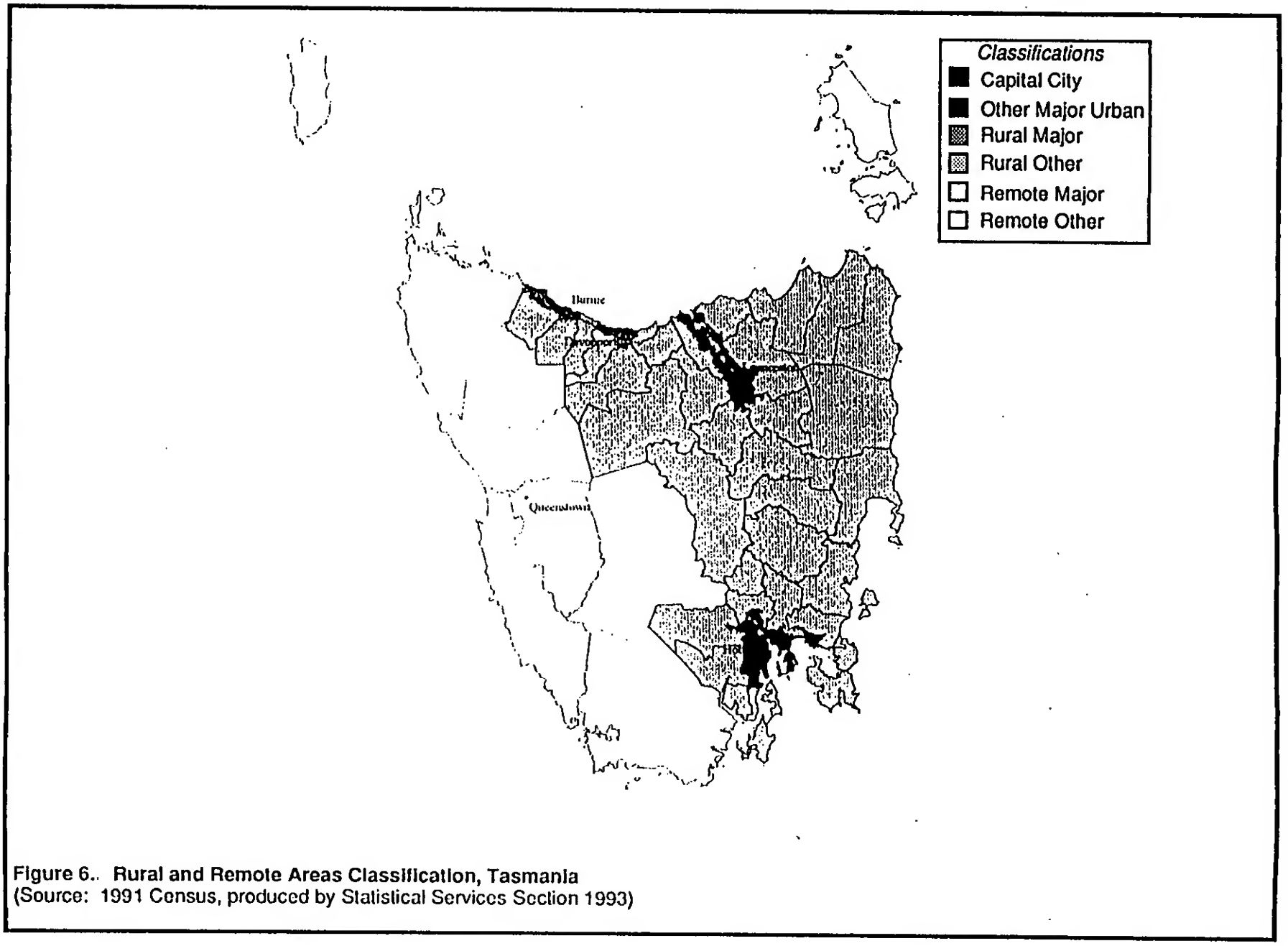

Figure 6.. Rural and Remote Areas Classification, Tasmania
(Source: 1991 Census, produced by Statistical Services Section 1993)

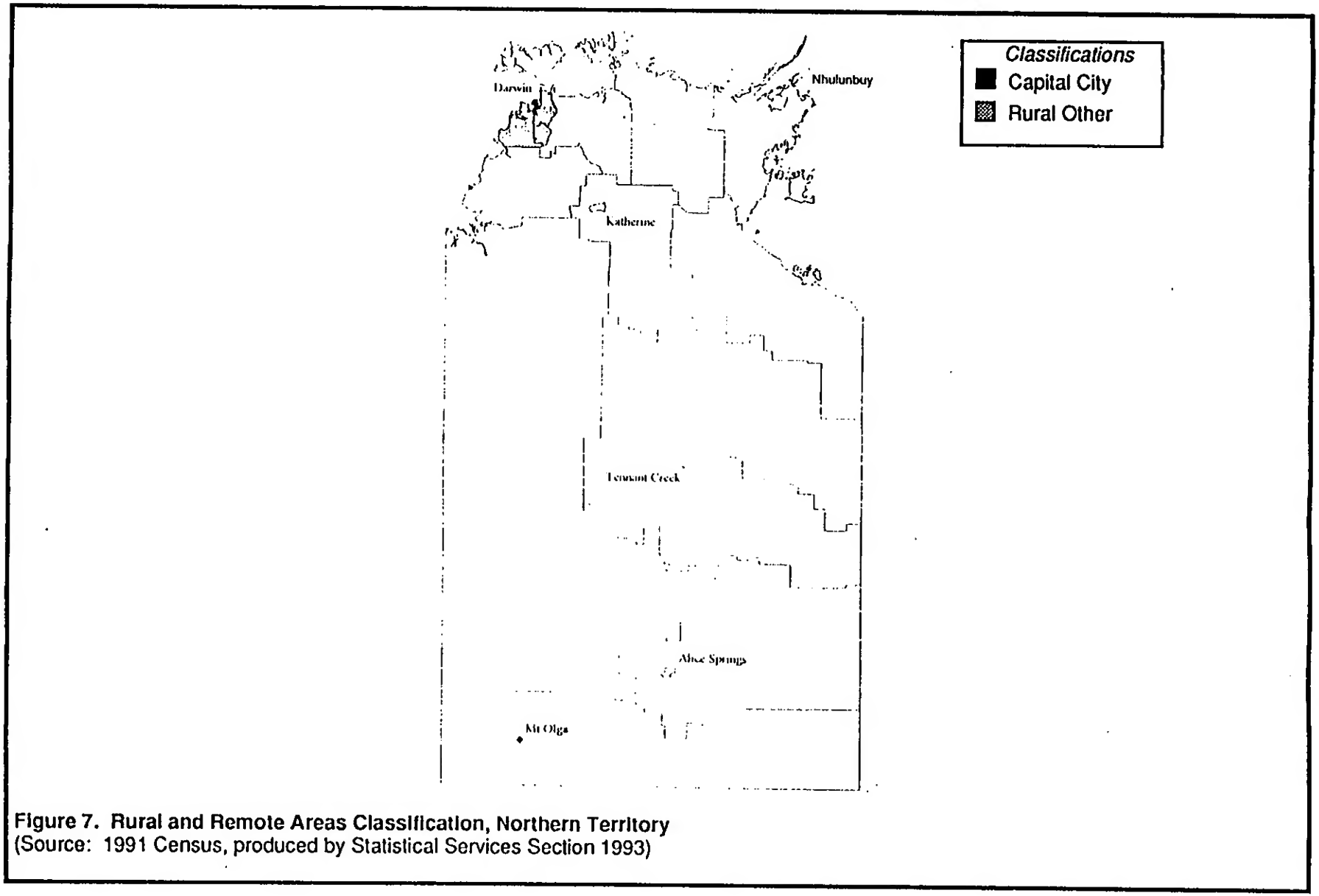

Figure 7. Rural and Remote Areas Classification, Northern Territory
(Source: 1991 Census, produced by Statistical Services Section 1993)

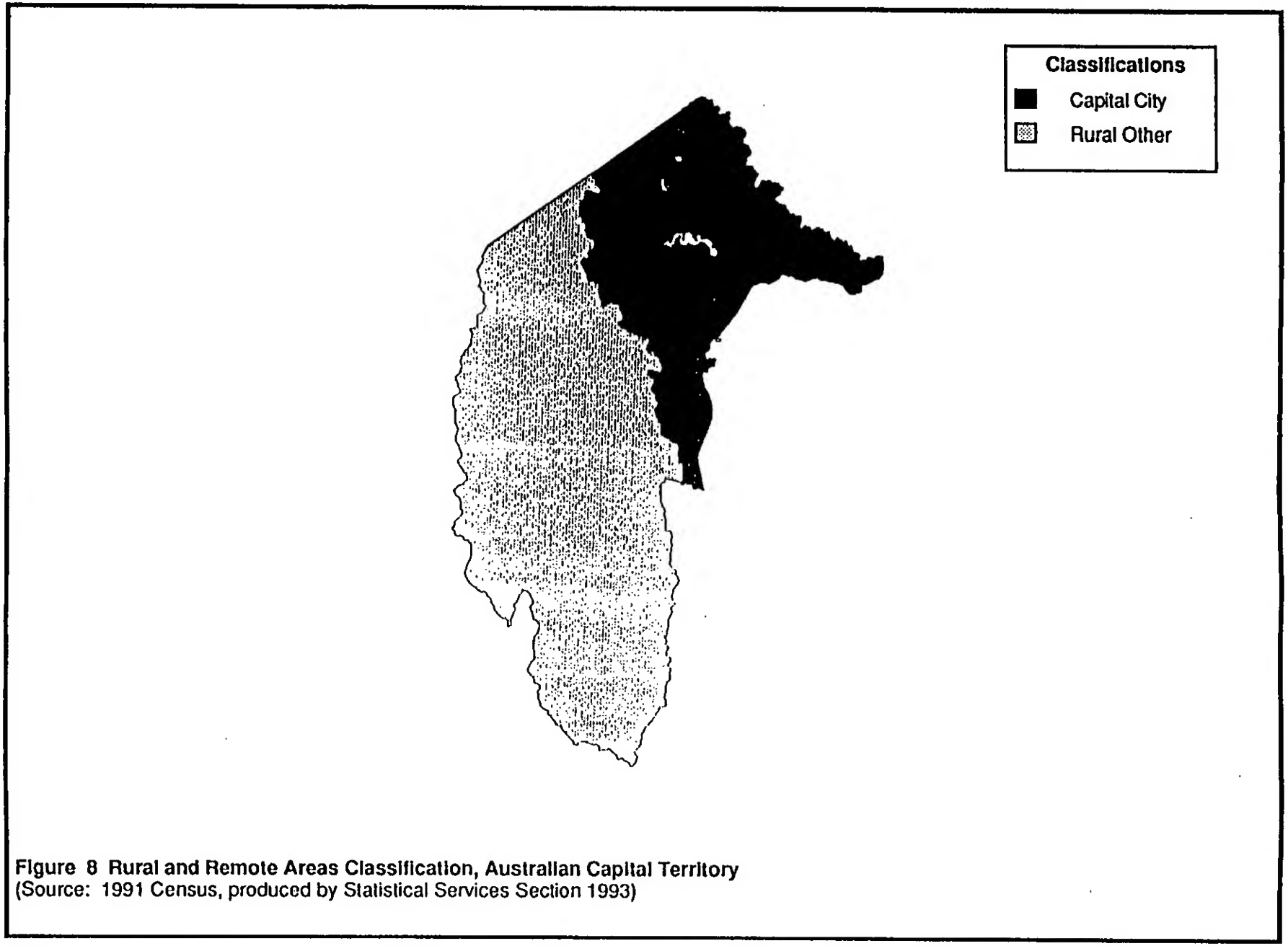

Figure 8 Rural and Remote Areas Classification, Australian Capital Territory
(Source: 1991 Census, produced by Statistical Services Section 1993)

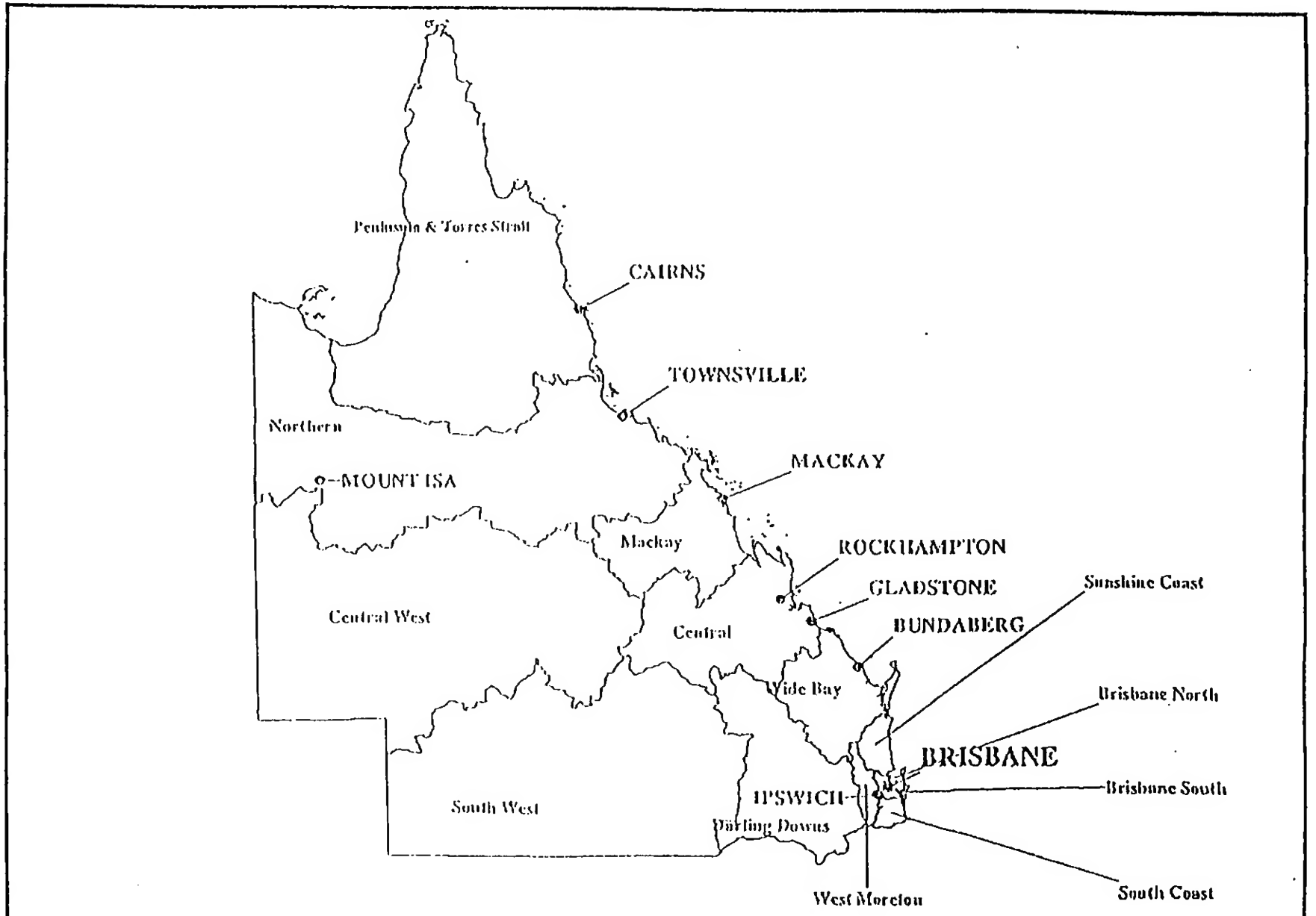

Figure 9. Queensland Health Regions and Major City Centres.

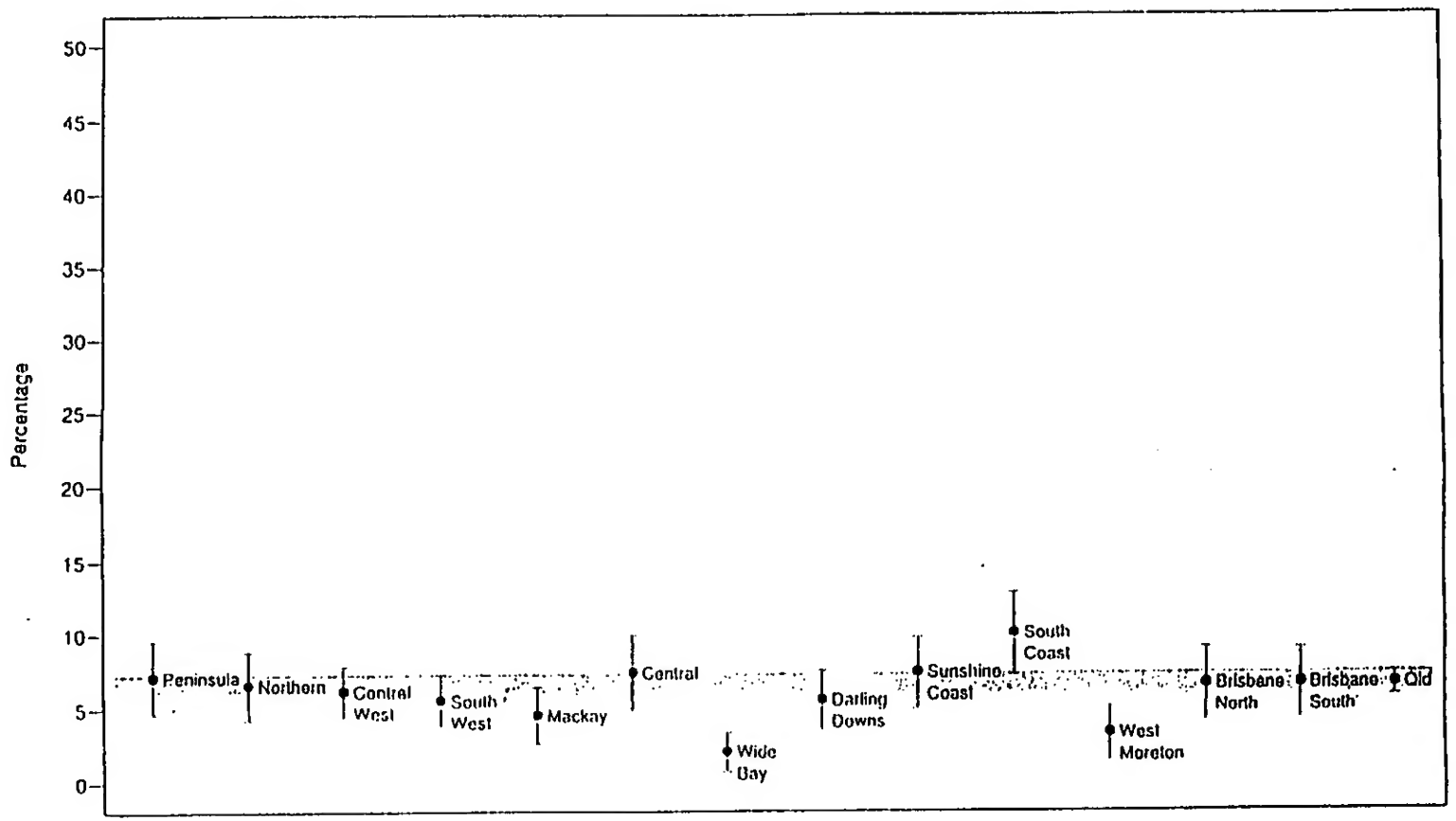

Figure 10. Females at moderate or high risk of harm from alcohol consumption, Queensland Health Regions and Major City Centres.

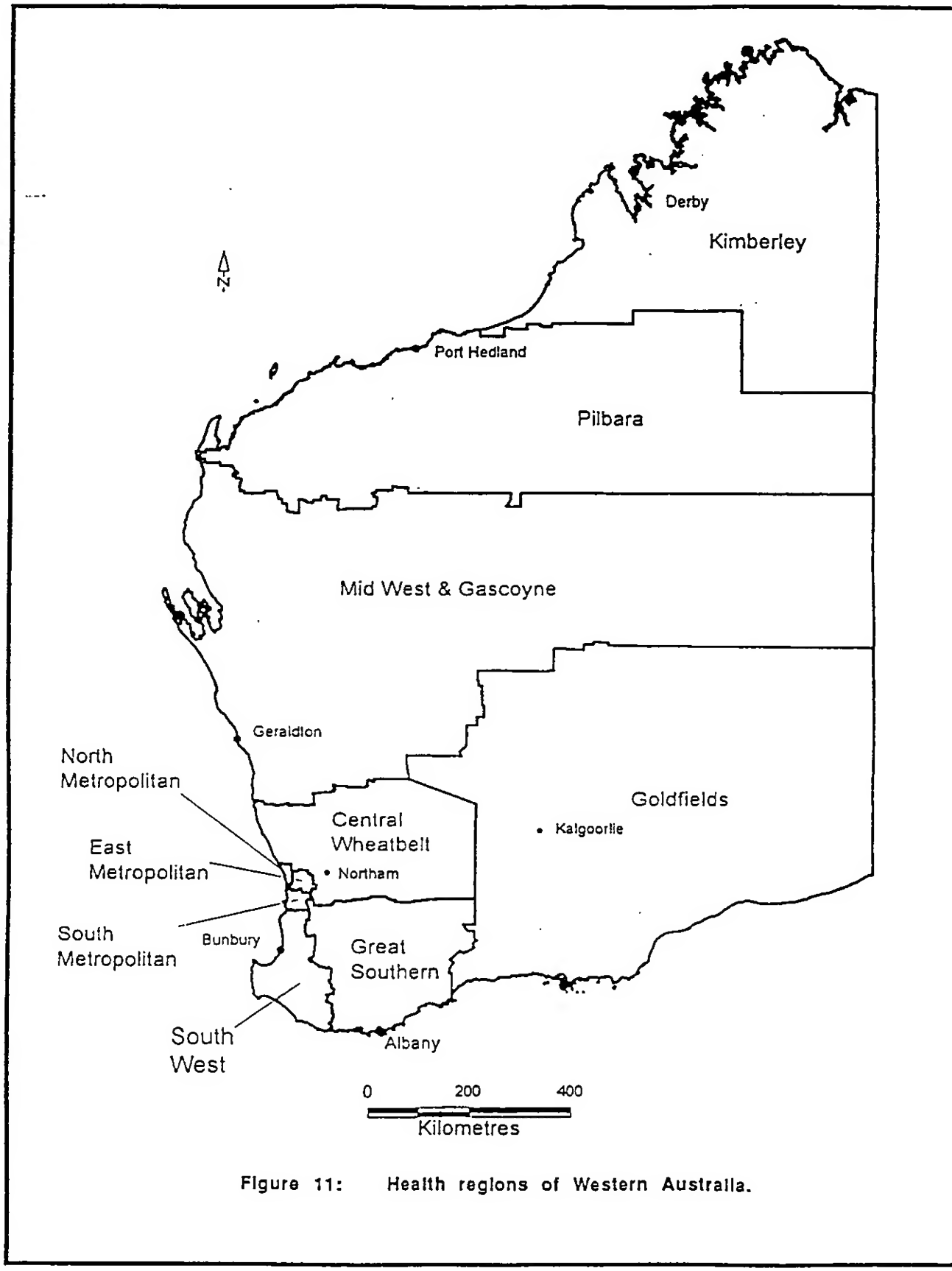

Figure 11: Health regions of Western Australia.

APPENDIX B

Table 1:
Alcohol related morbidity for females in 1990.
(Crook 1994, 9).

Health region	Rate Per 100,000	Separations
Wide Bay	508	404
South West	*484*	*65*
Peninsula	460	423
Central West	460	30
Northern	399	410
Brisbane North	390	898
Central	375	297
Queensland	*357*	*5165*
Darling Downs	331	333
Mackay	321	170
Sunshine Coast	317	470
South coast	294	465
West Moreton	287	213
Brisbane South	273	849

Table 2:
Alcohol related mortality in Queensland Health regions in 1990 for females (Crook 1994, 15).

	ALCOHOL			
	Males		Females	
Health region	R	N	R	N
Brisbane North	44	98	28	65
Brisbane South	37	114	28	86
Central	49	41	26	20
Central West	60	5	29	2
Darling Downs	42	42	24	24
Mackay	31	17	18	9
Northern	50	56	23	24
Peninsula	60	58	30	27
South Coast	39	60	25	40
South West	*69*	*10*	22	*3*
Sunshine Coast	48	69	25	37
West Moreton	34	26	23	17
Wide Bay	53	43	33	26
Queensland	*44*	*642*	*26*	*378*

Table 3:
Risk levels among drinkers, NT and Australia compared. (1992 NT Survey and 1989-90 National Health Survey)*.

Drinking Category	% of drinkers			
	Female		Male	
	Australia	N Territory	Australia	N Territory
Responsible	85.6	79.4	79.7	61.3
Hazardous	11.3	13.1	10.6	20.2
Harmful	3.1	7.4	9.6	18.5
Total	100.0	100.0	100.0	100.0

*The terminology used in the Australian National Health Survey is 'low risk', 'medium risk' and 'high risk' but the NH and MRC terms used here are synonymous with these terms.

Table 4:
Percentage of people who consumed alcohol by type of community and sex (Watson *et al.* 1988, 12).

Community Type	Female		Male	
	Number	Per Cent	Number	Per Cent
Town Camp	68	64.8	86	83.5
Major Community	74	14.2	333	67.7
Cattle Station	10	17.2	26	51.0
Outstation	35	14.3	95	50.3
Total	187	20.1	540	64.7

Table 5:
Percentage of people who consumed alcohol by type of community and location (Watson *et al.* 1988, 12).

Community Type	Females	
	Top End	Katherine/ Centre
Town Camp	78.8	58.3
Major Community	10.7	19.9
Outstation	1.4	19.5
Cattle Station	*	17.2
Total	14.5	25.0

*Empty cell

Table 6:
Estimate of the amount of alcohol in grams consumed daily by females when drinking (percentage of female drinkers) (Watson *et al.* 1988, 17).

Amount of alcohol in grams	Female Drinkers	
	Number	Per Cent
1-20 g (responsible)*	28	15.0
21-40 g (hazardous)*	24	12.8
More than 41 g (harmful)*	127	67.9
Not known	8	4.3
TOTAL	187	100.0

*According to National Health and Medical Research Council Guidelines, 1988.

Table 7:
Hospital admissions for alcohol caused conditions of women by health region and Aboriginality, Western Australia 1981-1990 (Veroni *et al.* 1993, 20).

Health Region	Total			Female Aborigines			Non-Aborigines		
	N	ASR	SE	N	ASR	SE	N	ASR	SE
Kimberley	204	208	15	140	342	30	64	160	26
Pilbara	170	94	8.5	69	335	42	101	72	8.5
Midwest and Gascoyne	280	99	6.0	161	694	58	119	48	4.5
Central Wheatbelt	174	72	5.5	64	1409	187	110	47	4.5
Goldfields	250	112	7.3	98	810	88	152	77	6.5
Great Southern	218	67	4.6	118	1801	181	100	32	3.2
South West	349	57	3.1	58	1090	161	287	48	2.9
North Metropolitan	885	48	1.6	50	462	70	835	45	1.6
East Metropolitan	1393	70	1.9	170	1173	103	1223	62	1.8
South Metropolitan	1021	54	1.7	90	592	67	931	51	1.7
All Regions	5062	66	0.9	1040	679	22	4022	53	0.9

Notes: ASR = age standardised rate (per 100,000 person-years); SE = standard error.

Table 8:
Age-standardised hospital admissions rates of women for selected alcohol caused conditions by health region, Western Australia 1981-1990 (Veroni *et al.* 1993, 24).

	Females									
	Abuse		Liver Disease		Psychosis		Gastritis		Dependence	
Health Region	ASR	SE	ASR	SE	ASR	SE	ASR	SE	ASR	SE
Kimberley	65	8.4	23	5.6	14	3.8	10	2.8	90	10
Pilbara	30	4.7	6.6	1.8	18	4.3	1.5	1.3	34	4.7
Midwest and Gascoyne	28	3.2	6.6	1.7	9.1	1.8	5.3	1.4	48	4.2
Central Wheatbelt	24	3.2	6.6	1.6	6.3	1.6	4.2	1.3	27	3.4
Goldfields	28	3.6	6.8	1.9	16	2.8	7.5	1.8	52	5.0
Great Southern	17	2.4	4.7	1.2	9.0	1.7	5.0	1.2	31	3.1
South West	18	1.8	4.3	0.8	4.2	0.8	1.2	0.4	28	2.2
North Metropolitan	9.2	0.7	6.7	0.6	2.8	0.4	0.9	0.2	28	1.2
East Metropolitan	12	0.8	6.9	0.6	4.4	0.5	2.5	0.4	43	1.5
South Metropolitan	11	0.8	6.4	0.6	3.3	0.4	0.6	0.2	32	1.3

Notes: ASR = age standardised rate (per 100,000 person-years); SE = standard error.

Table 9:
Tobacco related mortality in Qld health regions in 1990 for females.
(Crook 1994, 15).

	Females	
Health Region	R	N
Brisbane North	62	143
Brisbane South	49	152
Central	47	37
Central West	30	2
Darling Downs	46	46
Mackay	33	18
Northern	45	46
Peninsular	42	38
South Coast	47	74
South West	54	7
Sunshine Coast	56	82
West Moreton	48	36
Wide Bay	51	40

Note: R = Rate per 100 000 population
N = drug related deaths

Table 10:
Tobacco related morbidity for females in 1990
(Crook 1994, 11).

Health Region	Rate per 100 000	Separations
Central West	541*	35
South West	*485**	*65*
Wide Bay	441	351
Sunshine Coast	401	594
Central	387	306
Darling Downs	376	379
Queensland	*374*	*5412*
Peninsula	371	341
Northern	368	378
West Moreton	363	269
Mackay	351	186
Brisbane North	350	807
Brisbane South	336	1042
South Coast	315	498

Note: The asterisks mean that the number of separations was greater than expected based on the population of the region.

Table 11:
Females who currently smoke in Queensland by Health Region and age.

Health Region	Age range		
	18-30	31-50	Over 50
Peninsular & Torres Strait	27.8	22.1	9.2
Northern	30.8	16.9	15.2
Central West	25.6	22.7	17.9
South West	30.4	25.7	18.3
Mackay	27.6	21.8	4.7
Central	32.3	21.6	14.0
Wide Bay	27.9	19.2	8.0
Darling Downs	19.7	17.7	11.0
Sunshine Coast	30.8	28.2	10.7
South Coast	34.8	27.4	13.0
West Moreton	34.6	29.6	6.8
Brisbane North	27.1	10.2	9.5
Brisbane South	31.5	25.6	11.0
Total Queensland	*29.8*	*21.8*	*10.8*

Note: Whilst the confidence level range is between 4 and 6 points for the Total Queensland figures, it is mostly over 15 and as high as 20 for the 18-30 cohort, between 10 and 14 for the 31-50 cohort and between 9 and 14 for the over 50s cohort.

Table 12:
Percentage of females smoking and chewing tobacco by location.
(Watson *et al.*1988, 24,27).

	Smoking		Chewing	
Location	Number	Per cent	Number	Per cent
Top End	311	72.5	63	4.7
Katherine	54	34.6	79	50.0
Centre	31	9.0	211	61.3
TOTAL	396	43.6	352	37.9

Table 13:
Percentage of females smoking and chewing tobacco by age.
(Watson *et al.*1988, 22,26).

	Smoking		Chewing	
Age group	Number	Per cent	Number	Per cent
15-20 years	65	41.9	35	22.6
21-30 years	111	43.4	71	27.7
31-40 years	85	45.9	70	37.8
41-50 years	61	39.4	79	50.3
51-60 years	40	43.5	51	55.4
>60 years	34	39.5	47	54.7
TOTAL	396	42.6	352	37.9

Table 14:
Women who take pain relievers by health region in NSW (in the two weeks prior to interview).

Region	Percentage
Wentworth	47.7
Northern Sydney	48.1
Central Coast	47.9
Central Sydney	45.3
South East	41.9
New South Wales (total)	41.7
Orana Far West	41.0
South West	40.2
North Coast	37.5
Central Western	35.6
New England	31.1

Table 15:
Percentage of females consuming analgesics by location (Watson *et al.* 1988, 27).

Location	Number	Per cent
Top End	338	78.8
Katherine	144	92.3
Centre	300	87.2
TOTAL	782	84.2

Table 16:
Percentage of females consuming analgesics by age (Watson *et al.* 1988, 29).

Age	Number	Per cent
15-20 years	121	78.1
21-30 years	225	87.9
31-40 years	159	85.9
41-50 years	134	86.5
51-60 years	78	84.8
>60 years	65	75.6
TOTAL	782	84.2

Table 17:
Women living in non-metropolitan South Australia who attended a DASC treatment service between 1 July 1993 and 31 May 1994.

Substance of use	No. of clients using*	% of women clients
Alcohol	104	61.9
Opiates	58	34.5
Cannabis	48	28.6
Tobacco	43	25.6
Benzodiazepines	36	21.4
Amphetamines	22	13.1
Antidepressants	8	4.8
Barbiturates	4	2.4
Cocaine	4	2.4
Hallucinogens	3	1.8
Inhalants	1	0.6
Depressants	1	0.6
Stimulants	1	0.6
Other Drugs	7	4.2

*Clients can report using more than one substance.

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